



State Health Care Reform: Key Questions and Answers

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Executive Summary

Popular Claims versus Scholarly Evidence

Claim	Evidence
<i>People without health insurance have no access to care.</i>	Among those with comparable incomes, the uninsured get about the same amount of health care as those with insurance once they seek care.
<i>Insuring people will eliminate uncompensated care.</i>	The largest amounts of uncompensated care are generated by Medicare and Medicaid patients. This occurs because Medicaid and Medicare pay providers less than cost. Eliminating the uninsured by putting them on Medicaid may actually increase the amount of uncompensated care by eliminating the payments the uninsured make for their own care, increasing utilization and increasing administrative overhead. In the 1990s, Tennessee insured everyone in the state under the TennCare program. The program was supposed to eliminate uncompensated care, but by the late 1990s uncompensated care had increased. ¹
<i>Health insurance is unaffordable for individuals.</i>	In Colorado, a 40-year-old woman can choose from a number of comprehensive health insurance policies that cost less than \$100 a month. Adding two children costs about \$50 to \$100 a month more. The most this woman would have to pay for health insurance, regardless of health status, would be \$425 a month under Cover Colorado, the state's risk pool, or insurance plan, for the uninsurable.
<i>Medicare has lower administrative costs than private insurance plans; private insurers have administrative costs of 30 percent.</i>	Recent papers suggest that Medicare administrative costs are similar to those in the private sector — even ignoring the fact that Medicare is not solvent. ² Overhead is not necessarily bad. It includes case management for patients with chronic conditions, health education expenses, fraud detection and customer service, areas in which Medicare is notoriously weak. ³ In 2002, the Washington State Office of the Insurance Commissioner determined that administrative expenses for companies filing annual statements with the state averaged 12.6 percent of overall revenues.
<i>Mandating electronic health records will lower costs and improve quality.</i>	Evidence from existing systems suggests that results are mixed and that there are significant concerns with record availability, accuracy and security.
<i>Mandating evidence-based medicine will lower costs and improve quality.</i>	Where evidence-based medical decision-making processes have been implemented, there are indications they are used to control costs by denying access to effective therapies.
<i>Care coordination and case management will lower costs.</i>	Experiments with disease management have lowered costs in some cases but not in others. Case management for expensive events like trauma is already routine for private insurers. Ongoing experiments concentrate on managing some chronic conditions known to generate avoidable costs.

Claim

Because the United States has the highest per capita health care spending, it “spends too much on health care.”

The U.S. health system spends more money and has poorer outcomes than health systems in other countries.

More spending on the indigent will improve health outcomes.

Integrated health care systems will lower costs.

People are better off if their health insurance policies have lower deductibles and pay for routine care.

The uninsured get their care at the emergency room, driving up costs for everyone.

Centralizing administration will lower costs.

Evidence

Not all higher spending is waste. Wealthier people spend more on health in order to function better, just as they spend more on housing, transportation and entertainment. Countries with lower levels of health care spending have worse health outcomes than the United States along a variety of measures. Within the United States, vacationers admitted to emergency rooms in high-spending areas have lower mortality rates than similar visitors in lower spending areas.⁴

The medical literature shows the opposite. Disparities between health care access for the rich and poor are lower in the United State than in other countries. A few examples of comparative outcomes include: lower U.S. infant mortality rates, higher cancer survival rates, better population blood pressure control, lower mortality and morbidity from cardiac disease, better diabetes treatment, more preventive care, and better health and quality of life for spinal cord injury patients. Compared to the British National Health Service, U.S. medical care provides more services for roughly the same expenditures.⁵

Spending on the indigent has risen significantly and there is little evidence of positive effects. It may be time to study how money is spent rather than simply spending more.

Integrated health care systems have raised costs in states such as Wisconsin, where hospital networks use primary care practices to provide patients for their higher margin hospital services and as barriers to competition. Colorado has determined that Medicaid managed care costs more than its current fee-for-service system, possibly due to higher overhead costs.⁶

Buying insurance for expected expenses is the most expensive way to purchase medical care. Lower deductibles come with higher premiums. Someone spending \$10,000 on health insurance with a \$500 deductible might be able to buy a policy with a \$5,000 deductible for \$5,000 a year and save the remaining \$5,000 in a tax-free health savings account. The higher deductible makes this person better off if his health expenses for the year are less than \$5,000.

A recent look at a census of all frequent users of Massachusetts emergency rooms suggests that ER use by the uninsured is roughly the same as for the privately insured. The Urban Institute has concluded that the uninsured do not use emergency rooms at a higher rate than the insured.⁷

If this were true, the Soviet Union would have had the lowest costs in the world. In fact, smaller systems tend to have lower administrative costs. Counter-evidence for the superiority of competitive systems includes a comparison of the Northern California Kaiser Health Plan with the British National Health Service. Researchers found that costs were comparable but that Kaiser provided more for the money.⁸

Claim

Insurance company profits increase the cost of care.

Evidence

There is a great deal of evidence showing that for-profit entities minimize costs better than nonprofit entities. Competitive markets generally make price increases difficult. When that happens, the only certain way to generate profits is to cut costs. In some cases, the efficiencies created by the drive to minimize costs allow for-profit firms to provide services that are better and less expensive than their nonprofit competitors, even though the for-profit entities must pay higher taxes and shareholder dividends. There is no evidence that health insurers are making abnormal profits.

More preventive care for individuals will save money.

With the exception of things like childhood immunizations, the evidence suggests that many preventive care initiatives increase expenditures.⁹ This is because most preventive care consists of screening for early detection of diseases that are less expensive to treat if caught early. While screening lowers individual risk, it increases overall expenditures because the savings from the relatively small number of early cases detected are smaller than the total costs of screening the population. This is why there is more preventive care screening in the United States than in government-run health care systems. Individuals are more likely to pay more to lower their own risks; government accountants are more likely to be concerned with total expenditures.

¹ Data from the RAND Health Insurance Experiment suggest that “with no insurance at all, people would have spent about half the cost of free care.” Emmett B. Keeler, “Effects of Cost Sharing on Use of Medical Services and Health,” *Medical Practice Management*, summer 1992, page 318. Available at <http://www.rand.org/pubs/reprints/2005/RP1114.pdf>. Access verified December 10, 2007.

² See Merrill Matthews, “Medicare’s Hidden Administrative Costs: A Comparison of Medicare and the Private Sector,” Council for Affordable Health Insurance, January 10, 2006. Available at http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf. Access verified February 19, 2008; and Benjamin Zycher, “Comparing Public and Private Health Insurance: Would A Single-Payer System Save Enough to Cover the Uninsured,” Manhattan Institute, Medical Progress Report No. 5, October 2007. Available at http://www.manhattan-institute.org/pdf/mpr_05.pdf. Access verified February 19, 2008.

³ J. P. Wieske, “How High Loss Ratios Undermine Affordable Health Insurance,” Council for Affordable Health Insurance, May 2007. Available at http://www.cahi.org/cahi_contents/resources/pdf/n141lossratio.pdf. Access verified February 19, 2008.

⁴ Joseph H. Doyle, Jr., “Returns to Local-Area Health Care Spending: Using Health Shocks to Patients Far From Home,” National Bureau of Economic Research, Working Paper No. 13301, August 2007.

⁵ Richard G. A. Feachem, Neelam K. Sekhri and Karen I. White, “Getting more for their dollar: a comparison of the NHS with California’s Kaiser Permanente,” *British Journal of Medicine*, No. 324, January 19, 2002, pages 135-143.

⁶ In its December 2006 Joint Budget Committee hearings, the Colorado Department of Health Care Policy and Financing wrote, “Although managed care organizations should experience savings over fee-for-service due to their improved ability to reduce unnecessary hospitalizations, emergency room visits, and other overutilization, there are also extensive administrative costs for care management, utilization management, providing networking to ensure access, and other processes such as bill paying and risk management.” See “FY 07-08 Joint Budget Committee Hearing,” Colorado Department of Health Care Policy and Financing, December 19-20, 2006, page 55. Available at http://www.chcpf.state.co.us/HCPF/Budget/jbc%2007-08%20hearing/FY%2007-08%20HCPF%20Hearing%20Agenda%20and%20Response_new.pdf. Access verified October 16, 2007.

⁷ Stephen Zuckerman and Yu-Shu Shen, "Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?" *Medical Care*, Vol. 42, No. 2, February 2004, pages 176-182.

⁸ Feachem, Sekhri and White, "Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente."

⁹ Tammy O. Tengs, "Dying Too Soon: How Cost-Effectiveness Analysis Can Save Lives," National Center for Policy Analysis, Policy Report No. 204, May 1997. Available at <http://www.ncpa.org/studies/s204/s204.html>. John D. Graham, "Comparing Opportunities To Reduce Health Risks: Toxin Control, Medicine and Injury Prevention," National Center for Policy Analysis, Policy Report No. 192, June 1995. Available at <http://www.ncpa.org/studies/s192/s192.html>.

Introduction¹

One of the biggest problems in health care reform is that parties with different viewpoints do not agree on basic facts. Some view the private sector as the source of U.S. health care woes and an expansion of government control as the solution. Others believe that ill-considered government interference is the main source of the problem. Simple logic dictates that it is nearly impossible to agree on a workable reform plan without agreement on a set of basic facts about what needs to be reformed. Many state reforms fail this test. This study poses some key questions the many state initiatives have failed to adequately address and makes some recommendations for successful evidence-based reforms.

There are three main components of successful reform. First, the central focus of any serious reform effort should be a vibrant and competitive free market for private health care, with a wide choice of physicians and treatments and a variety of ways to pay for them. There should also be a competitive market for private health insurance, one that offers a wide choice of health plans.

By contrast, excessive government regulation — especially requiring guaranteed issue and community rating — cripples markets for individual health insurance, increases health insurance costs for large numbers of people, expands dependence on government programs, and retards innovation in health care delivery and coverage. The Massachusetts decision to impose guaranteed issue and community rating in the early 1990s put its individual insurance market on life-support and ultimately led to the adoption of the 2006 reform legislation. Similar regulations had comparable effects in other states, with the result that individuals in New Jersey, Maine, Tennessee, Kentucky, New York and Vermont were denied choice in their health insurance. [See Appendix A for some specific questions about health care reform.]

Second, consumer-directed health care initiatives, under which individuals manage some of their own health care dollars through Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), are superior to first-dollar coverage, especially under insurance programs designed and controlled by government. There is considerable evidence that consumer-directed programs reduce costs. When the cost of health care drops, health insurance premiums drop, and paying cash for care becomes easier. Paying cash further reduces costs by eliminating the overhead costs of third-party payment, with the result that more people can receive better health care for the same money. However, there is no evidence that expansion of government health programs decreases costs. In fact, there is evidence that such programs actually increase costs.

Third, in view of the compelling evidence that government control of medical practice can degrade care and increase costs, any successful health

“The key elements of sound health care reform are competition, consumer control and deregulation.”

care policy reform should: 1) substantively reform government programs, 2) introduce incentives to eliminate waste, and 3) reduce costly and unneeded administrative and regulatory burdens. These are the source of the largest cost problems in the current health care delivery system.

“A health insurance mandate forces people to buy a product they may not want at a price they cannot control.”

Do We Need Individual Mandates?

Many things can be more important than having health insurance, including buying food, paying for housing, having a job and having reliable transportation to get to that job. An individual insurance mandate ignores this by requiring everyone to purchase the kind of health insurance the government stipulates, regardless of cost and before he or she meets other household needs. It also ignores the fact that having health insurance does not guarantee medical care — which is a particular problem in government programs with reimbursement rates so low that physicians and hospitals choose not to participate.

The philosophical issue of what constitutes minimal health insurance is likely to be a much larger problem than is commonly recognized. Some advocates favor requiring policies with low deductibles and low plan limits, such as a \$100 deductible and a maximum benefit of \$50,000. Others favor requiring policies designed to cover catastrophic events, with deductibles of thousands of dollars and plan limits in the millions of dollars. Although individual insurance needs vary with such factors as age, location, health status, wealth, income, medical care preferences and the propensity to travel, most proposals do not take these differences into account.

For example, the Colorado Blue Ribbon Commission for Health Care Reform proposed establishing an unelected, unaccountable panel to periodically review what the government will accept as a minimum health insurance policy. Benefits would be adjusted as needed. Families would be required to pay for those minimum benefits whether or not they are a good value relative to other household needs. At present, many people pay cash for their dental care. It is more expensive to pay for dental care via insurance because of the additional costs of insurance company profit and overhead. Should the panel arbitrarily decide that the minimum benefit package must include dental care, overall expenditure on dental care would increase.

The imposition of an individual mandate with minimum coverage requirements will likely mean that thousands of people who currently have health insurance will find that their policies do not meet the minimum standards because their deductibles are “too high” for the officials defining the minimum standards, or because their policies lack certain benefits. These decisions will be made by a regulatory body that has no direct knowledge of the incomes, assets, health status or values of the individual policyholders. This is what is happening under the failing Massachusetts health reform plan.

From an individual's point of view, a mandate is a tax. By forcing people to buy a product they may not want at a price they cannot control, the individual mandate functions as a potentially unlimited tax for health insurance. People who currently get health care but have no insurance will be required to purchase insurance, thus increasing their costs. People who are allegedly unable to purchase insurance because it is unaffordable will have to be subsidized to a larger extent than they are at present. Funding those subsidies will require direct tax increases that will raise costs for all citizens, whether those increases are in the form of taxes on insurance premiums, provider taxes, sales taxes or increases in the income tax.²

People generally say that they do not buy health insurance because they cannot afford it. As elected officials cannot require that the impoverished spend money they do not have on insurance they cannot afford, individual mandates are almost always coupled with extensive subsidies for health insurance purchase. This means that the enforcement and administration of an individual mandate requires the collection of substantially more income data than is currently available to determine who qualifies for subsidies.

Although the Massachusetts plan has been in operation only since April 1, 2006, it has already generated a 13-page "Certificate of Exemption" application that allows people to ask for an exemption from the individual health insurance mandate if they can demonstrate sufficient financial hardship. Among other things, hardship is defined as a notice of eviction or utility shutoff, or a natural disaster or human-caused event that substantially damages individuals, their homes or their possessions. People are also exempted if they can establish that purchasing health insurance would cause a "serious deprivation of food, shelter, clothing or other necessities." In effect, the individual mandate in Massachusetts requires citizens to petition the government for relief whenever they suffer a serious financial reversal. Even with extensive subsidies, Massachusetts authorities have exempted an estimated 20 percent of the uninsured from the mandate on the basis of their inability to afford health insurance.

How can such a mandate be enforced? The Colorado proposal contemplates requiring proof of coverage when registering for school, and when applying for or renewing a driver's license or car registration. People who cannot show proof of coverage will be fined a year's worth of premiums when they file their state income taxes. This would significantly increase government control over individual decisions in normal household matters. Furthermore, it is unlikely that an individual mandate can be fairly enforced. Most states mandate automobile liability insurance, but large numbers of motorists drive without it.³ The ability to enforce a health insurance mandate is of particular concern in areas where large numbers of the uninsured are illegal aliens who may not file tax returns.

"Most states mandate automobile liability insurance, but large numbers of motorists drive without it."

Should Government Decide How Medicine Should Be Practiced?

The Colorado Commission also recommends establishing an Orwellian-sounding “Improving Value in Health Care Authority” to “fundamentally realign incentives” in the Colorado health care system by regulating provider payments and determining acceptable treatments. The proposal recommends that the Authority study the “best scientific evidence to foster clinically, ethically, and culturally appropriate end-of-life care.” However, based on what has happened in other cases when such recommendations have been put into practice, the Authority will likely end up transferring control over medical practice from individual citizens and their doctors to unaccountable, unelected regulatory authorities.

The potential for harm is made clear by a recommendation to “Pay providers based on quality, such as use of care guidelines, performance or quality measures, coordination of patient care, and use of health information technology.” While the proposal never defines quality, it is confident that the Authority will know it when it sees it. Physicians who do not do what the Authority demands will face financial penalties. If what the Authority wants differs from what patients want, physicians will have an incentive not to act in the best interests of their patients. The Commission did not explain why it believes that the Authority will do a better job of aligning incentives than a program of deregulation that puts smart shoppers using their own money in charge of their own health care decisions.

The pay-for-quality recommendation means the Improving Value in Health Care Authority will end up using evidence-based measures to regulate physician behavior and, ultimately, medical practices. At present, physicians are free to disregard evidence-based recommendations that conflict with their experience in clinical practice or with their patients’ wishes. Physician freedom of action is crucial to good medical care because it protects physicians and patients from regulators with an agenda or conflicting values.

The U.S. National Heart, Lung and Blood Institute’s JNC 7 clinical guidelines for treating hypertension provide a recent example of how agenda-driven research can create seriously flawed evidence-based national guidelines. They have the potential to increase patient morbidity and mortality. The guidelines recommend starting all patients with high blood pressure on thiazide-type diuretics. In support of this, the guideline for primary care physicians states:

“Thiazide-type diuretics have been the basis of antihypertensive therapy in most outcome trials. In these trials, including the recently published Antihypertensive and Lipid Lowering Treatment to Prevent Heart Attack Trial (ALLHAT), diuretics have been virtually unsur-

“‘Pay for performance’ allows government to tell doctors how to practice medicine.”

passed in preventing the cardiovascular complications of hypertension.”⁴

This statement is grossly misleading. In fact, the ALLHAT study has been subjected to withering criticism and the JNC 7 guidelines are not widely accepted. In Britain, the National Institute for Health and Clinical Excellence recommends ACE inhibitors as the first choice for initial therapy in patients younger than 55. The guidelines also ignore evidence suggesting that diuretics may increase the risk of developing new-onset type 2 diabetes. Newer antihypertensive drugs appear to have a beneficial or neutral effect on glucose and lipid metabolism.⁵

The Colorado Commission advocates combining evidence-based standards with the pay-for-performance rules. If the Improving Value in Health Care Authority follows this recommendation, it might use the results from poorly designed clinical trials to pressure physicians to use less expensive, older and less effective therapies, regardless of their relatively poor side-effect profiles or of their effect on individual patients. The Commission recommendations also set the stage for various methods of provider profiling, including hospital and physician report cards, two currently fashionable quality initiatives which have been shown to have serious technical problems. They also give physicians an incentive to deny care to people who are very ill. Seriously ill people pose higher risks of poor outcomes.⁶

When such power is concentrated in the hands of an unaccountable group that has no personal contact with those affected by its decisions, patients become mere costs. Such groups tend to focus on costs and are highly susceptible to influence from narrowly focused interest groups with political agendas not in accord with what patients value. The danger is that access to advanced therapies for “expensive patients,” including the disabled, the chronically ill and those with complex medical needs, will be severely restricted. In the Netherlands, physician-caused deaths are increasingly commonplace. The utilitarian ethic adopted by the Royal Dutch Medical Society has virtually eliminated any prosecution of physicians who kill the elderly, the mentally ill or the disabled.⁷

Does Universal Coverage Lower Health Care Costs?

The governing assumption of U.S. health care policy is that people who can afford health care should subsidize essential care for those who cannot. Yet, those who must pay for people who cannot pay for themselves deserve an efficient system for providing subsidized care — one that minimizes costs. It should be noted that by international standards, virtually everyone in the United States, regardless of ability to pay, does get health care.

*“‘Evidence-based medicine’
may create incentives to deny
people care.”*

Individual health insurance mandates are usually combined with large subsidies to people judged unable to afford health insurance. This is likely to increase the cost of existing government programs designed to ensure that those unable to pay get essential health care — in part, by encouraging people who presently pay for their own health care to stop doing so.

Even if users of Veterans Health Administration hospitals are counted as uninsured, studies suggest that the uninsured pay for at least half of their own health care.⁸ Expanding public programs to cover people who are already paying for their care eliminates such payments. As health insurance is an expensive way to buy health care, it is possible that it may actually be less expensive to provide care under the existing mixture of public subsidies and private charities than under a system created by mandatory health insurance. There is no compelling case that mandated health insurance buttressed by a large new bureaucracy dedicated to the control of insurance markets and medical practice, and to extensive income redistribution, is the lowest-cost method of providing health care to those who need it but cannot pay.⁹

Contrary to popular belief, the uninsured use emergency rooms at about the same rate as the insured.¹⁰ Generous estimates of uncompensated care for the uninsured suggest that it is about 3 percent to 5 percent of private insurance premiums, which is probably less than the taxes proposed under most universal coverage proposals.¹¹

It is not clear to what extent estimates of premium increases caused by “cost shifting” include uncompensated care for those nominally insured under such government programs as Medicare and Medicaid.¹² In Washington state, Milliman, Inc. estimated that the cost shift from Medicare and Medicaid to private payers was 14.3 percent of commercial hospital costs, or about 4.8 percent of commercial premiums. Of the typical commercial health insurance premium of \$850 a month per family in 2004, the government program shifted costs of about \$490 a year. Physician underpayment by government programs was higher.¹³ Thus, expanding Medicaid and Medicaid-like programs runs the risk of expanding uncompensated care. These expansions also increase utilization and encourage people to substitute government payments for health care for their own payments. For example, TennCare, the Tennessee Medicaid expansion designed to insure everyone, promised to reduce uncompensated care. Some years later, however, uncompensated care costs had increased. Tennessee radically changed the program after its cost threatened to bankrupt the state.¹⁴

“Government health care spending crowds out private spending.”

There are also disincentives to work created by the high marginal tax rates people who receive subsidies will face as their incomes rise. People are free to make choices between leisure and labor, part-time work and full-time work, and high paying jobs and jobs that pay less but are more congenial. Proposals for rich subsidies for health insurance may increase the number of people who choose lower incomes in order to qualify for taxpayer-supported

programs. This appears to be a particular problem with the State Children's Health Insurance Program/Children's Health Plan Plus (SCHIP/CHPP) in Colorado, where an estimated 6 out of 10 new enrollees dropped private insurance to participate in the subsidized public program. The crowd-out rate is higher as more high-income families become eligible for coverage. And, contrary to assertions that waiting periods can control crowd-out, economist Jonathan Gruber found that "the anti-crowd-out efforts that have accompanied the SCHIP program have probably raised crowd-out more than lowering it."¹⁵

The Colorado Commission recommends subsidizing any household with an income between 300 percent and 400 percent of the federal poverty level that cannot buy employer group insurance and spends more than 9 percent of its income on health insurance.¹⁶ This means that any family of four with an income of \$61,950 that spends more than \$5,576 on health insurance, and any family of four with an income of \$82,600 that pays more than \$7,434, is eligible for subsidies. According to the 2006 Consumer Expenditure Survey, families in this income bracket spent 5.3 percent of their household incomes on entertainment, 4.3 percent of their incomes on cash contributions, 3.8 percent of their incomes on household furnishings and equipment, and 5.5 percent of their incomes on food away from home. In view of this spending pattern, meeting a 9 percent premium burden would not seem to be impossible for these households, and subsidizing them would seem to place an unfair burden on other taxpayers.

"Many of the uninsured see health insurance as a bad deal at current prices."

Focusing on payments for health insurance discriminates against people who substitute cash savings for insurance, and only purchase health insurance that covers very large expenses. People who purchase a health insurance policy with a \$10,000 deductible may never pay more than 9 percent of their incomes for health insurance but may occasionally have total health expenses that exceed 9 percent of income in one or two years. Encouraging the purchase of health care using third-party payment and discriminating against cash payments raises costs by increasing administrative overhead.

One reason given for imposing an individual mandate is to limit the need for subsidies by requiring that everyone spend money on government-defined health insurance. The fact that people who have low medical expenditures are exceptionally resistant to purchasing standard insurance policies indicates that simply expanding the insurance model is a mistake unless regulators also act to lower economic costs. A substantial number of the uninsured see health insurance as a bad deal at current prices. Shifting that bad deal to taxpayers does little to change the cost/benefit tradeoff.

The estimated elasticity of demand for individual insurance — the percentage change in policies bought divided by the percentage change in price — ranges from -1.0 to -0.3. This suggests that a 10 percent increase in insurance premiums results in a 3 percent to 10 percent decline in the number

of policies purchased. Poor families without access to group coverage who are not eligible for public plans are least likely to purchase individual insurance, regardless of the subsidy. Married couples tend to be less affected by price increases, while single people are more sensitive. One study found that even substantial subsidies for individual insurance would “have modest effects on the number of uninsured.”¹⁷

In Wisconsin, a 2004 evaluation of the BadgerCare program speculated, “the mere perception of the premium [3 percent of income above 150 percent of the federal poverty level] could be holding back applicants who would not be required to pay it.”¹⁸ Kate Bundorf and Mark Pauly found that the likelihood of purchasing health insurance increases with expected health expenditures, and that this effect is more likely to be observed in the large group market than in the individual market.¹⁹ They reported that in 2002 the average employee payment for single coverage was \$450 per month — about the average expected health expenditure for a 25-to-29-year-old man. Bundorf and Pauly concluded that if the wage difference between jobs with and without health insurance “reflects the average premium for coverage (\$3,060 for single coverage in 2002), the reduction in wages associated with coverage may generate income effects for low-income workers that make jobs with coverage unattractive relative to those without coverage.” If people with the largest expected health costs are already insured, estimates of the savings from insuring the uninsured may be overstated.

“Taxpayer subsidies make unwanted coverage attractive to the uninsured.”

For employer-provided insurance, economists Jonathan Gruber and Ebonya Washington used results from the transition of federal employees to pretax health insurance premiums over the 1991-to-2002 period to estimate the effect of after-tax price on insurance takeup and plan choice. They found that lower premium shares led people to choose more expensive plans but had little effect on overall plan choice. They point out that targeting people who are already offered employer-subsidized insurance but refuse it is very costly. The reason: The fact that these people have already turned down a highly subsidized product means that they are exceptionally price sensitive or already have insurance from another source. They estimated that the federal government spent \$31,000 to \$83,000 per newly insured person.²⁰ This conclusion is roughly in line with the results in Maine, where the DirigoChoice program spends almost \$16,000 to insure one additional uninsured person.²¹

Economic theory predicts that people with smaller medical expenditures will be more sensitive to the price of health insurance than those with larger, and less discretionary, medical expenditures. Empirical support for this supposition suggests that individuals self-select into insured or uninsured status depending on their knowledge of their own health. This self-selection means that the uninsured are not an isolated population subgroup, and to insure the majority of people it is necessary to change behavior at relatively high levels of the income distribution.

There is little evidence that insurers “cherry pick” and sort across plans, suggesting that worries about adverse selection in insurance markets are likely exaggerated. This means that the regulatory schemes proposed to correct the problem — mainly guaranteed issue and community rating — are unnecessary, and likely do more harm than good.²²

Another problem is that means-tested subsidies are potentially extremely unfair and create a disincentive to act responsibly. For example, if the Colorado Commission recommendations are followed, the state could end up taxing a young married couple with employer-provided health insurance, a baby and an income of \$25,000 to provide health insurance subsidies to an older married couple with substantial home equity and retirement savings, three children, an annual income of \$68,000 and a business that does not provide health insurance.

“Means-tested subsidies are often extremely unfair.”

In order to provide more health care for all at a lower cost, other options need to be explored and evaluated, including: subsidized clinics, designated hospitals to which those who cannot pay can be transferred, removing the regulations that discourage physicians from participating in charitable activities and charitable organizations from operating such programs, insurance plans that provide small benefits for low cost, reducing unnecessary licensing barriers and scope of practice restrictions, and insurance plans that offer catastrophic benefits. [See Appendix B for some specific recommendations.]

What Is the Best Use of Government’s Health Care Dollars?

Historically, tax-supported health care programs have focused on two areas: public health programs to limit environmental health hazards and the spread of infectious and communicable diseases, and public programs providing individual care for people unable to provide it for themselves — primarily children, the frail and impoverished elderly, people with grievous injuries or diseases, and people with severe birth defects or developmental disabilities.

There is a finite amount of tax money available to subsidize health care. The Colorado proposal would divert substantial resources to areas in which state government has little prior experience and, in some cases, a poor record of success. These include extensive recordkeeping on large numbers of complex transactions for every individual in the state, developing and deploying effective information technology architectures that are new and untested, developing new regulations for every area of medical practice, developing and promoting wellness initiatives of dubious merit, vastly expanding means-testing for subsidies, enforcing the health insurance mandate, and extensively researching systems design.

Tax money spent on these initiatives is tax money not available for projects to ameliorate the conditions of those with serious disease or disability. This

is of particular concern in view of the fact that many of the people who testified before the Commission were concerned about inadequate care under existing public subsidy systems.

Should We Encourage Consumer-Directed Health Reforms?

For the purposes of this discussion, consumer-directed accounts are sums of money that people control, benefit from and can spend at will on certain broadly designated categories. In health care, these amounts are usually combined with health insurance policies that have lower premiums, and deductibles of at least \$1,100. If people save money on health care, savings accumulate in their health savings account (HSA). HSA balances belong to the individual account-holder, accrue interest tax-free and can be spent on any medical expense recognized by the Internal Revenue Service. HSA balances can be willed to beneficiaries. After age 65, funds can be used for other purposes. Health Reimbursement Accounts (HRAs) are not owned by individuals and HRA balances may be lost when an individual changes employers. Health care reforms that arbitrarily limit financing choices to a few government-approved options are not consumer-directed.

Most proposals for universal coverage do not promote any of the consumer-directed private or public-sector initiatives that have been reducing costs and improving health since the late 1990s.

The use of consumer-directed accounts coupled with high-deductible health insurance policies (HSA/HDHP) has grown rapidly since their inception in December 2003. There were 1 million HSA/HDHP accounts open by March 2005. The number rose to 4.5 million by January 2007. Projections recently released by America's Health Insurance Plans, an industry group, forecast that the use of HSAs will double in the coming year, and that the use of all consumer-directed products will more than triple. In employer-sponsored plans, the Mercer National Survey of Employer-Sponsored Health Plans suggests that enrollment in consumer-directed health plans has risen to 5 percent of all employees. The 2007 average cost per employee for HSA plans is \$5,679, roughly \$700 less than the average \$6,644 cost for managed care, preferred-provider plans (PPOs) with deductibles of at least \$1,000. Mercer comments that this "lends support to the theory that the account feature encourages more careful health spending."²³

Private insurers have already begun to increase coverage and lower costs using consumer-directed account-based products. The lower premiums associated with HSA/HDHP policies have helped reduce the number of uninsured: An estimated 27 percent of the 1 million people covered by individual HSA/HDHP policies in force by January 2007 previously had no health insur-

"Consumer-directed accounts allow individuals to control their own health care dollars."

ance. They are particularly appealing to the young: 39 percent of the people covered by HSA/HDHP policies are under age 29. More than 80 percent of the policies offer disease management, covering conditions such as diabetes, coronary artery disease, congestive heart failure, asthma and chronic obstructive pulmonary disease. More than 85 percent of the companies writing HSA policies offered health education information, information on physicians, hospital-specific quality data and health care cost information. Seventy-two percent offered online personal health records. Policies that are owned by individuals are portable from job to job and, if purchased from a national company, are often portable when someone moves to another state.²⁴

“‘Cash-and-counseling’ accounts reduce costs and improve health for disabled Medicaid patients.”

Consumer-directed account-based reforms have also reduced costs and improved health for disabled Medicaid participants. The Colorado Consumer Directed Attendant Support Program, which enables people with disabilities to hire, train, supervise and fire their own attendants, has improved health while saving 20 percent or more on attendants for the disabled simply by freeing the participants from Medicaid regulation. Similarly, the flexibility that the Robert Wood Johnson Foundation’s “Cash & Counseling” accounts brought to Medicaid spending by the home-bound disabled in other states also increased access to needed services and reduced unmet needs.

Results from private-sector employers like Wendy’s, John Deere and Whole Foods suggest that account-based consumer-directed health insurance also increases the use of preventive care. Reports from other employers indicate that people covered by consumer-directed accounts are more compliant in their use of recommended medications and are more active in disease management programs.

A recent paper by Greg Scandlen reviewed the evidence on consumer-directed account-based health care reform and considered whether consumer-directed insurance has lived up to initial predictions. Scandlen concluded that initial indications suggest that account-based insurance is changing patient behavior by reducing the demand for unnecessary services, encouraging higher compliance with treatment recommendations, and increasing the use of preventive care. The rate of cost increases has decreased substantially for users of the account-based plans. There are early indications that account users are fueling a transformation of service delivery.²⁵

Are Electronic Medical Records The Answer?

Despite the assertion that centralized electronic medical records will cut costs, supporting evidence is lacking. Such data systems have yet to prove themselves in practice.²⁶

The evidence to date suggests that electronic medical records will increase the risk of misuse of individual health information. Identity theft is

already common. New criminal uses of individual health information include using someone else's name to get expensive health care services, or attempting to extort money from employers by threatening to publish patient records. A threat to breach patient confidentiality could lead to serious penalties under the 1996 Health Insurance Portability and Accountability Act (HIPAA), one of the goals of which was to ensure the privacy of patients' medical records.

Electronic records also increase the risk to state taxpayers, who could be liable for damages caused by stolen or misused records. The Veterans Health Administration, long praised for its electronic records, has repeatedly lost sensitive data on millions of patients and has spent tens of millions of dollars repairing the damage caused by such thefts.²⁷

Although popular mythology assumes that electronic records will reduce costs, the evidence from hospital-based systems is mixed. Hospital-based computerized order-entry systems for prescription drugs do appear to reduce medication prescribing errors, but at the possible cost of increased workloads and decreased human vigilance against error. Experts fear that this combination may harm patients in situations when rapid treatment is essential. There are scant data on whether electronic prescribing records improve health outcomes, and a small but growing literature on the new kinds of errors they facilitate.²⁸

Other problems with electronic records include how to control the propagation of errors, and differences between clinical and administrative records. Medical records contain errors, and those errors are neither reduced nor corrected by computerizing them. A November 21, 2007, Associated Press article described the errors that physicians found in their own medical records.²⁹ HIPAA does not require those who maintain health records to correct them. There are important questions about who should have the authority to alter electronic patient records. Data system robustness is a concern. There are also studies that have found that the records themselves change behavior. In the Veterans Health Administration system, a significant number of patient records have case notes that are electronically copied from one record to another in order to save time. The electronic medical records that result are bloated and obfuscated. They waste physician time, are inefficient, and do a poor job of rapidly conveying important clinical information.³⁰

A final problem is that the drive to use patient records for billing and monitoring may degrade their usefulness in patient care. Patient records were originally developed to help clinicians provide care. If administrators insist on standardizing them in order to use them for process control and provider evaluation, it is likely that clinicians will respond by not keeping notes that can be used against them. In Britain, hospital trusts have "adjusted" patient records in order to suggest that patients had been treated on time.³¹ In the United States, physicians already keep multiple sets of records. One is in the format

"There is little evidence that electronic prescribing improves health outcomes."

demanded by payers like Medicare. The other may be private notes that suit a physician's personal style and helps him facilitate patient care.

Are Guaranteed Issue and Community Rating the Answer?

A common belief is that having government pay for everyone with expensive medical conditions will lower insurance costs for everyone else. In 2004, presidential candidate Sen. John Kerry called for the federal government to pay for all medical expenses in excess of \$50,000. In the Colorado reform recommendations, this took the form of requiring all high-cost patients with certain pre-existing conditions to enroll in Cover Colorado, the state's guaranteed issue high-risk pool for the uninsurable, at rates equal to prevailing rates for people without severe illnesses. At present, the pool is funded by state tax funds and assessments on private insurers. Premiums are higher than those in the standard market to discourage people from forgoing health insurance until they are sick and then buying into Cover Colorado.

The Commission's plan would extend guaranteed issue to the individual insurance market. To make guaranteed issue more palatable, the Commission would shuffle high-cost individuals into a revamped Cover Colorado. The idea is that having government pay for high-cost individuals will offset the increased cost of guaranteed issue and will create premium stability.

These plans will not reduce insurer costs. Individual insurance underwriters currently have three options: Accept an individual application as written, decline the application, or accept it with conditions, such as waivers and ratings. In most states, insurers already charge higher prices for higher risks. People with specified pre-existing conditions who are "uninsurable" are already allowed to enroll in state-sponsored risk pools or to purchase a policy from the guaranteed issue provider at higher than standard rates with some subsidies for those with lower incomes. This means that guaranteed issue products are already available for many of those who need them, at rates that are already subsidized. As they are already out of the individual insurance market, promising to take them out will have little effect and there is no particular reason to believe that coupling government catastrophic insurance with guaranteed issue and community rating will create premium stability. There is every reason, based on experience in other states, to believe that premiums will rise significantly.

"High-risk insurance pools with subsidized premiums are already available for patients with pre-existing conditions."

Massachusetts is a real-world example of extending guaranteed issue and community rating to the individual insurance market. The Massachusetts plan penalizes the parents of healthy children and people who purchase health insurance before they get sick by increasing their premiums in order to offer lower premiums to others. This is inefficient and unfair. It raises the rates

“‘Guaranteed issue’ requires insurers to sell policies to the sick at the same premiums charged to the healthy.”

paid by the vast majority of people. In doing so, it discourages the purchase of private insurance coverage, especially in lower-income brackets where people are especially sensitive to premium price increases.

In contrast, Colorado achieves guaranteed issue for all by directly subsidizing insurance for the uninsurable and by letting those who act responsibly save by purchasing medically underwritten insurance in a market with far more flexible pricing. Rather than supporting a bureaucracy to control all health insurers, Colorado efficiently uses taxes to support a far more limited bureaucracy that focuses on providing coverage to thousands of residents who cannot purchase health insurance due to pre-existing conditions. In short, it achieves the Massachusetts result of making insurance available for everyone, and does so at a lower cost. The Massachusetts Connector Authority is now quoting individual insurance prices that are higher than those currently prevailing in Colorado. This is illustrated by the representative premiums given in Table I.

The academic literature on this is clear: Guaranteed issue and community rating increase costs and decrease coverage. Examples of statements from the literature include: “States limiting risk rating in individual insurance display lower premiums for high risks than other states, but such rate regulation leads to an increase in the total number of uninsured people;”³² “Community rating and guaranteed issue regulations produce only small changes

TABLE I

A Comparison of Massachusetts and Colorado Monthly Health Insurance Premiums

(as quoted to insurance brokers the week of December 3, 2007)

	Colorado Individual Market (ZIP: 80222)	Colorado Risk Pool Guaranteed Issue	Massachusetts (ZIP: 02101) Guaranteed Issue	
10-year-old child	\$102.00	\$125.30	\$193.81	\$2,000 deductible
40-year-old man	\$172.00	\$250.18	\$246.10	\$2,000 deductible

in risk pooling because the extent of pooling in the absence of regulation is substantial;³³ community rating and guaranteed issue “have succeeded only in making individual health insurance coverage more expensive and less available than it otherwise would have been;³⁴ “individual health insurance markets deteriorated after the introduction of GI and CR reforms...premium rates tended to increase, sometimes dramatically. We did not observe any significant decreases in the level of uninsured persons.”³⁵

“Guaranteed issue and community-rated premiums raise the cost of insurance.”

Furthermore, if the experiences in New York, Maine, New Jersey, Tennessee and Massachusetts are any guide, guaranteed issue and community rating will severely damage the individual insurance market, stop the consumer-directed insurance market in its tracks, stifle important health care innovations and lessen competition among insurers. This could expand the number of people who are uninsured or depend on government for health coverage.

Expanding the number of people on government programs could be costly if they are removed from innovative private programs designed to manage chronic health conditions. Among these successful programs:

- In Colorado, Aetna’s migraine headache management program reduced MRI use, increased the use of appropriate medications and improved the quality of life for migraine sufferers.
- The oncology management program of Great-West Healthcare, a group health insurer, reduced the rate of hospital readmissions by 17 percent by hiring nurse managers to help patients cope with treatment.
- Rocky Mountain Health Plans developed a diabetes management program that combined pay-for-performance measures with case management fees. It improved the percentage of diabetic members with good blood pressure control and increased the number of members with acceptable LDL-cholesterol levels.
- Pharmacists call all members of the Kaiser Permanente ALL program who have diabetes or coronary artery disease to ensure they are taking all of their medications.
- Humana analyzes monthly data on claims to ascertain whether people might benefit from its personal nurse coaching service.³⁶

Is a Massachusetts-Style Connector Part of the Answer?

A good deal has been written about connectors, also known as health insurance exchanges, since Massachusetts incorporated the concept into its reform measures. A recent academic analysis by John E. Schneider and others,

published by the Health Economics Consulting Group, says that the “connector” concept, as a proposed mechanism to move the commercial health insurance market away from an employer-sponsored environment to one that is individually based environment, holds certain “intuitive appeal.”³⁷ However, they note that there are numerous trade-offs and consequences that prevent such programs from accomplishing their goals.

The centralization of information envisioned by these programs is an unnecessary and costly addition to the administrative costs of health care coverage. In fact, well-developed mechanisms already exist to offer consumers the opportunity to search for and compare various health coverages. The Internet, coupled with the consumer-directed health insurance revolution, has simplified comparing, pricing and purchasing a health insurance policy. Various Internet and insurance carrier Web sites provide complete coverage descriptions and allow coverage comparisons. As is the case in other markets selling complex financial products, agents provide significant amounts of consumer education, act as ombudsmen to intervene with insurers on behalf of clients, and provide a check on insurer quality by refusing to market plans that treat customers poorly.

Other problems with connectors include:

- Displacement of existing coverage, which may stress remaining risk pools;
- Legal issues;³⁸
- Loss of product innovation and choice;
- Disproportionate risk and premium cost increases due to adverse selection — whether risk pools are voluntary or mandatory;
- Fairness in the allocation of risk and financial burden.

One of the major drawbacks of connectors is that they devolve into government-run managed competition schemes. The two best-known connector plans, the Federal Employee Health Benefits Program and the Massachusetts Commonwealth Connector Authority, put bureaucratic intermediaries and price controls between consumers and the health insurance they purchase.

Companies in the Federal Employees Health Benefit Program (FEHBP) survive by attracting healthy employees. Federal employees pay the same price regardless of their health status. If an insurer attracts employees in poor health, the company will have higher claims and will raise its premiums. Higher premiums will induce the relatively healthy to move to other plans. With only the unhealthy left, premiums will rise again. In the long run, the insurance offered in the federal system has evolved to provide less consumer choice — in some areas people may have a choice of only one plan — and less flexibility. The Massachusetts Connector Authority is also moving to reduce

“Insurance connectors give health plans incentives to attract the healthy and avoid the sick.”

choice for its voluntary plans. It estimated that its expenses would rise from \$24 million in 2007 to \$36 million in 2009.³⁹ Facing higher expenses, it is moving to offer fewer plans with less choice in an effort to control premium costs.

In important respects, connectors suffer from operating deficits identical to those that plague the FEHBP. After some government empowers an authority to run a connector, the connector's job is to match firms and individuals with private sector health insurers. As in the FEHBP, the government manages the competition between private health insurers. Under most connector plans this management takes the form of a requirement that every person of the same age be charged the same premium regardless of expected health care spending.

Blocked from competing on their ability to price and manage risk, insurers compete on their ability to reduce costs and attract only healthy people. Plan quality suffers and choices are inexorably reduced.⁴⁰

Does Modeling by the Lewin Group Bias State Choices?

In almost every case, the recommendations of the Colorado Commission were influenced by Lewin Group assumptions that having fewer entities providing a specific function would lower costs by reducing administrative overhead, and that centralized control would more effectively deploy resources than independent private actors governed by profit in a functioning market system. As explained in Appendix C, the Lewin Group model makes certain assumptions that implicitly bias its results toward finding that central planning will lower costs.

For example, the Lewin Group systematically overstates the cost of private insurance relative to public programs. It assumes that single-payer programs will have the same administrative costs as Medicare — about 1.8 percent of benefits. This ignores growing evidence that Medicare's overhead costs are much higher. For example, it ignores the administrative costs of supplemental policies required to fill the gaps in Medicare coverage. The Lewin Group also overstates private insurance administrative expenses.

Lewin bases its assumptions about physician administrative costs on a survey of just 335 physician practices self-selected from a statistically unrepresentative sample. It assumes millions of dollars in savings on building occupancy costs and on furniture and equipment from centralized purchasing and volume discounts. Lewin also assumes benefits for physician support staff will fall 12.5 percent under single-payer, and the cost of administrative duties by medical assistants and registered nurses will drop 66 percent. It is unlikely that moving to a single-payer system will reduce patient record keeping or the

“The assumptions behind the Lewin Group model are biased toward central planning.”

amount of office space needed to see patients. These assumptions likely produce inflated estimates of cost savings.

Similar assumptions plague Lewin's treatment of hospital cost reductions under single-payer. It assumes that hospital costs for data processing are reduced by 36 percent. It also estimates patient accounting, credit and collection, and admitting costs will be reduced by 50 percent, 90 percent and 40 percent, respectively. For reasons that are unclear, the model assumes that medical records costs will be reduced by 10 percent. Depreciation and amortization are assumed to be reduced 23 percent. Apparently, when government runs things capital does not depreciate and interest costs are no longer a consideration. Social work services are assumed to fall 50 percent under a government plan. Finally, maintenance and repairs and plant operations are each assumed to fall 23 percent. Apparently repairs will be less frequent when a single payer controls operations.⁴¹

"Lewin overstates private administrative costs and understates government costs."

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

- ¹ This study is based on Linda Gorman and R. Allan Jensen, “Minority Report,” in Blue Ribbon Commission for Health Care Reform, *Final Report to the Colorado General Assembly*, January 31, 2008, Chapter 10. Available at <http://www.lobbycolorado.com/FileRepository/documents/FinalReport01312008.pdf>. Access verified February 19, 2008.
- ² With respect to Colorado, the Lewin Group has presented a number of charts showing average family health spending by income group under various reform proposals. Usually the groups shown are incomplete and the numbers presented do not provide a picture of overall spending or how many families are in each group. They also do not include the economy-wide effects of various tax increases on jobs, business formation and incomes. In slide 18 of a November 15, 2007, presentation, the effect on people with incomes below \$50,000 was given for each \$10,000 in income. For amounts above \$50,000 the increments increased to \$24,999 and then to \$49,999. In 2004-2006, the Census Bureau put median household income in Colorado at \$54,039. As the chart is restricted to averages between income groups, it is impossible to know what will happen to overall average spending. The November 1, 2007, interim report by the Lewin Group stated that “About 70.4 percent of all Colorado families would see a net increase in health spending of \$20 or more.” The Lewin Group, *Colorado Model 5: Cost and Coverage Impacts*, November 15, 2007, powerpoint presentation to the Blue Ribbon Commission on Health Care Reform, Denver, Colorado. Final report, revised November 28, 2007, slide number 18; Lewin Group, *Technical Assessment of Health Care Reform Proposals*, an interim report prepared for the Colorado Blue Ribbon Commission for Health Care Reform, November 1, 2007, page 122.
- ³ Greg Scandlen, “Will Mandatory Health Insurance Work?” National Center for Policy Analysis, Brief Analysis No. 569, September 6, 2006. Available at <http://www.ncpa.org/pub/ba/ba569/>.
- ⁴ National Heart, Lung and Blood Institute, “JNC 7 Express: The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure,” U.S. Department of Health and Human Services, National Institutes of Health, NIH Publication No. 03-5233, December 2003, page 7. Available at <http://www.nhlbi.nih.gov/guidelines/hypertension/express.pdf>. Access verified November 28, 2007.
- ⁵ There is a growing amount of literature exploring possible relationships between treatment for high blood pressure and the onset of type 2 diabetes. For an example, see Effie L. Kuti, William L. Baker and C. Michael White, “The development of new-onset type 2 diabetes association with choosing a calcium channel blocker compared to a diuretic or beta-blocker,” *Current Medical Research and Opinion*, Vol. 23, No. 6, June 2007, pages 1,239-1,244; Sameer Stas, Lama Appesh and James Sowers, “Metabolic safety of antihypertensive drugs: myth versus reality,” *Current Hypertension Reports*, Vol. 8, No. 5, September 2006, pages 403-408.
- ⁶ For sample literature on the topic of problems with quality measurement and report cards see Timothy P. Hofer et al., “The Unreliability of Individual Physician ‘Report Cards’ for Assessing the Costs and Quality of Care of a Chronic Disease,” *Journal of the American Medical Association*, Vol. 281, No. 22, June 9, 1999, pages 2,098-2,105; Rachel Sorokin, “Alternative Explanations for Poor Report Card Performance,” *Effective Clinical Practices*, Vol. 3, No. 1, January/February 2000, pages 25-30; David M. Shahian et al., “Comparison of Clinical and Administrative Data Sources for Hospital Coronary Artery Bypass Graft Surgery Report Cards,” *Circulation*, Vol. 115, No. 12, March 27, 2007, pages 1508-1510; Sharon-Lise T. Normand et al., “Assessing the Accuracy of Hospital Clinical Performance Measures,” *Medical Decision Making*, Vol. 27, No. 1, January/February 2007, pages 9-20; Andrew J. Epstein, “Do Cardiac Surgery Report Cards Reduce Mortality? Assessing the Evidence,” *Medical Care Research and Review*, Vol. 63, No. 4, August 2006, pages 403-426; Harlan M. Krumholz et al., “Evaluation of a Consumer-oriented Internet Health Care Report Card: The Risk of Quality Ratings Based on Mortality Data,” *Journal of the American Medical Association*, Vol. 287, No. 10, March 13, 2002, pages 1,277-1,287.
- ⁷ For a general discussion of the Dutch experience see Ezekiel Emanuel, “Whose Right to Die?” *Atlantic Monthly*, Vol. 279, No. 3, March 1997, pages 73-79.
- ⁸ For an example of a case in which care provided by the Veterans Health Administration (VHA) is counted as care for the uninsured, see Jack Hadley and John Holahan, “How Much Medical Care Do the Uninsured Use, And Who Pays For It?” *Health Affairs*, Web exclusive, February 12, 2003. The problem, of course, is that the VHA is not supposed to serve those who are not veterans. The second problem is that people meeting the criteria for lifetime health care from the VHA might rationally consider themselves insured and would not purchase private policies or enroll in other public ones.
- ⁹ Helen Levy and David Meltzer, “What Do We Really Know about Whether Health Insurance Affects Health?” Catherine G. McLaughlin, ed., *Health Policy and the Uninsured* (Washington, D.C.: Urban Institute Press, 2004), Chapter 4.
- ¹⁰ For examples see Jesse M. Pines and Kevin Buford, “Predictors of frequent emergency department utilization in Southeastern Pennsylvania,” *Journal of Asthma*, Vol. 43, No. 3, April 2006, pages 219-223; B. C. Sun, H. R. Burstin and T. A. Brennan,

“Predictors and Outcomes of Frequent Emergency Department Users,” *Academic Emergency Medicine*, Vol. 10, No. 4, April 2003, pages 320-328; K. A. Hunt et al., “Characteristics of Frequent Users of Emergency Departments,” *Annals of Emergency Medicine*, Vol. 48, No. 1, July 2006, pages 1-8; K. K. Fulda and R. Immekus, “Frequent Users of Massachusetts Emergency Departments: A Statewide Analysis,” *Annals of Emergency Medicine*, Vol. 48, No. 1, July 2006, pages 6-16; Peter J. Cunningham, “What Accounts for Differences in the Use of Hospital Emergency Departments across U.S. Communities?” *Health Affairs*, Web exclusive, Vol. 25, No. 5, September/October 2006, pages 324-336; Stephen Zuckerman and Yu-Shu Shen, “Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?” *Medical Care*, Vol. 42, No. 2, February 2004, pages 176-182. Urban Institute researchers Zuckerman and Shen concluded that “The uninsured do not use more [ER] visits than the insured population as is sometimes argued.” In fact, “the publicly insured are overrepresented among [ER] users.”

¹¹ The Lewin Group estimated that total Colorado health spending is about \$30 billion. This implies that the estimated cost of uncompensated hospital care for the uninsured in Colorado is less than 3 percent of overall spending. In another context, the Lewin Group estimated that about 40 percent of the Colorado hospital shortfall is passed along to private payers. If correct, this would suggest that hospital care for the uninsured is about 1 percent of total spending. The reform proposal created by the Commission would increase health spending in Colorado by \$2.7 billion, \$854 million of which would come from an increase in personal income taxes. Blue Ribbon Commission for Health Care Reform, *Final Report to the Colorado General Assembly*, January 31, 2008, pages 38 and 119.

¹² In a personal communication with the Commission staff, the Lewin Group cited a paper on physician pricing by Thomas Rice et al. as a source for its assumption that shortfalls in reimbursement were passed along to private payers in the form of higher hospital charges. However, Rice’s paper discussed the effect of changes in Medicaid compensation on the volume of services provided; thus, Lewin’s reference to this paper was apparently in error. The remainder of the communication simply said that “Our [Lewin’s] own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e., revenues minus costs) in public programs were passed on to private payers in the form of the cost-shift during the years studied. Based upon this research, we estimate that 40 percent of increases in reimbursement would be passed back to payers in the form of reduced charges.”

¹³ Will Fox and John Pickering, “Payment Level Comparison Between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians,” Premera Blue Cross, May 2006. Available at https://www.premera.com/stellent/groups/public/documents/pdfs/dynwat%3B5604_632535561_3160.pdf. Access verified February 19, 2008.

¹⁴ PriceWaterHouseCoopers, *Actuarial Review of Capitation Rates in the TennCare Program*, March 1999, Comptroller of the Treasury, State of Tennessee.

¹⁵ Jonathan Gruber and Kosali Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” National Bureau of Economic Research, Working Paper No. 12858, January 2007, page 28.

¹⁶ Nine percent was chosen because research suggests that 75 percent of people with incomes in the subsidy range considered spending 9 percent or less on health care.

¹⁷ M. Susan Marquis et al., “Subsidies and the Demand for Individual Health Insurance in California,” *Health Services Research*, Vol. 39, No. 5, October 2004, page 1,564. To develop its estimates of coverage, the Lewin Group uses an average price elasticity of -0.34 percent to estimate the price elasticity of the demand for health insurance. Its estimate is derived from data from the Current Population Survey for 1987 to 1997. However, the Lewin Group goes on to say that it varies the elasticities that it uses by income. For those with incomes of \$10,000 the income elasticity is assumed to be -0.55. For those with incomes of \$100,000 the price elasticity is assumed to be -0.09. While the Lewin assumptions may be among the most reasonable available, how accurately this application of elasticities mirrors actions in the real world is unknown. The Lewin Group, “Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System, Appendix D: The ‘Solutions for a Healthy Colorado’ Proposal,” December 29, 2007, page D-11.

¹⁸ Chris Swart, Nina Troia and Dorothy Ellegaard, “BadgerCare Evaluation,” Wisconsin Department of Health and Family Services, Office of Strategic Finance, Evaluation Section, July 2004, page 54. Available at <http://dhfs.wisconsin.gov/aboutDHFS/OPIB/policyresearch/BadgerCare07-04.pdf>. Access verified February 19, 2008.

¹⁹ M. Kate Bundorf, Bradley Herring and Mark Pauly, “Health Risk, Income, and the Purchase of Private Health Insurance,” National Bureau of Economic Research, Working Paper No. 11677, September 2005.

²⁰ Jonathan Gruber and Ebonya Washington, “Subsidies to Employee Health Insurance Premiums and the Health Insurance Market,” National Bureau of Economic Research, Working Paper No. 9567, March 2003.

²¹ Tarren Bragdon, “Eight Challenges for Dirigo Health in 2006,” *DirigoWatch*, Vol. 3, No. 1, January 30, 2006.

²² Patrick Bajari, Han Hone and Ahmed Khwaja, “Moral Hazard, Adverse Selection and Health Expenditures: A Semiparametric Analysis,” National Bureau of Economic Research, Working Paper No. 12445, August 2006; M. Susan Marquis and Melinda

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- ²⁴ Hannah Yoo, “January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans” AHIP Center for Policy and Research, April 2007. Available at http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf.
- ²⁵ Greg Scandlen, “Working as Intended: What We Have Learned About Consumer Driven Health Care,” Consumers for Health Care Choices, November 2007. Available at <http://www.chcchoices.org/publications/CDHP.pdf>. Access verified February 19, 2008.
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- ²⁷ “VA could spend \$20M on data breach response,” *FierceHealthIT*, June 17, 2007. Available at <http://www.fiercehealthit.com/story/va-could-spend-20m-on-data-breach-response/2007-06-18>. See also Daniel Pulliam, “VA sets aside \$20 million to handle latest data breach,” *Government Executive*, June 14, 2007. Available at http://www.govexec.com/story_page.cfm?articleid=37191&ref=relink. Access verified March 4, 2008.
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- ²⁹ “Errors clearer on other end of the stethoscope,” *Associated Press*, November 21, 2007. Available at <http://www.msnbc.msn.com/id/21918092/>. Access verified February 19, 2008.
- ³⁰ For an introduction to one segment of the argument against electronic medical records in their current form see Robert E. Hirschtick, “Copy-and-Paste,” *Journal of the American Medical Association*, Vol. 295, No. 20, May 24/31, 2006, pages 2,335-36; and Robert E. Hirschtick, “Copy-and-Paste-and-Paste—Reply,” *Journal of the American Medical Association*, Vol. 296, No. 19, November 15, 2006, pages 2,315-16.
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- ³² Mark V. Pauly and Bradley Herring, “Risk Pooling and Regulation: Policy and Reality in Today’s Individual Health Insurance Market,” *Health Affairs*, Vol. 26, No. 3, May/June 2007, pages 770-779.
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- ³⁵ Leigh Wachenheim and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets* (Brookline, Wis.: Milliman, Inc., August 2007).
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- ³⁹ “Plan of Operations: Three Year Financial Plan/Budget,” Commonwealth Health Insurance Connector Authority, December 14, 2006.
- ⁴⁰ See “Is Managed Competition the Answer?” in John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World* (Lanham, Md.: Rowman & Littlefield, 2004), Chapter 2.
- ⁴¹ The Lewin Group, “Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System, Appendix F: “Colorado Health Services Program” Single-Payer Proposal,” prepared for the Colorado Blue Ribbon Commission for Health Care Reform, Denver, Colorado, December 29, 2007, pages F-3 to F-11.

APPENDIX A

Key Questions That Should Be Asked About State Health Care Reform Proposals

- I. Does the proposal organize the health care system so as to provide maximum value to those who use its services, with value defined from their point of view?**
 - A. Pricing
 - (1) Does the proposal further market pricing for medical services? Does it rely on price controls of any kind, including administrative price setting?
 - (2) Does the proposal ensure that any physician or health provider, and any facility, is free to treat any patient in exchange for direct payment of a mutually agreeable fee?
 - B. Outcomes
 - (1) Does the proposal ensure that patients can determine the treatments they will receive and physicians the treatments they will provide, subject to their own consciences?
 - (2) Does the proposal include organizational provisions that ensure that firms, industries, professionals and subsidy recipients will not be able to use the reform plan to their financial advantage?
 - C. Consumer protection
 - (1) Does the proposal ensure that participation in government programs is voluntary?
 - (2) Does the proposal encourage people to accumulate assets that may be used for future health care expenses in lieu of third party insurance?
 - (3) Does the proposal allow people to modify the amount of financial risk they are willing to bear by choosing among different third party insurance policies as their circumstances change?
 - (4) Does the proposal remain neutral with respect to the form that third party insurance should take as long as insurers can meet their contractual obligations?
 - (5) Does the proposal remain neutral with respect to paying for health care with cash or with third party insurance?
 - (6) Does the proposal subject businesses operating in health care to the same rules as businesses operating in other sectors of the economy with respect to anti-trust, ownership, pricing, contracting and reporting requirements?
 - (7) Does the proposal protect people from involuntary participation in any non-governmental insurance program?
 - (8) Does the proposal allow the purchase of health insurance that is not associated with an employer?
 - (9) Does the proposal ensure that people can buy health insurance from any insurance company approved by a state government?

- (10) Does the proposal allow for the fact that people purchase health care from a variety of sources, some of which are both outside their state of residence and outside of the United States?
- (11) Does the proposal protect consumers from arbitrary restrictions on their ability to access medical therapies?

D. Government obligations

- (1) Does the proposal include mechanisms to ensure that government programs do not use government power to compel unpaid services from providers?
- (2) Does the proposal have mechanisms to ensure that government treats all providers fairly and does not discriminate between providers via different payments for the same service or regulatory structures that favor some providers over others?

II. Does the proposal contain adequate structures for reducing costs?

- A. Does the proposal ensure that all providers and third party payers in the health care systems are subject to credible competitive threats?
- B. Does the proposal expose existing providers, including government and quasi-government entities, to competitive pressures?
- C. Does the proposal ensure that all entities using or providing health care are free to contract with others as they see fit?
- D. Does the proposal ensure that participation in any health care program under the control of state government, or any entity created by statute, is voluntary?
- E. Does the proposal ensure that any physician or health provider, and any facility, is free to treat any patient in exchange for direct payment of a mutually agreeable fee?
- F. Does the proposal ensure that for profit and non-profit providers are treated equally?

III. Does the proposal contain adequate regulatory reform?

- A. How does the proposal plan to determine which health care regulations produce a net benefit and which produce a net cost?
- B. Does the proposal embrace legal reforms that protect participants from unreasonable torts and contradictory regulations?
- C. Does the proposal require that businesses operating in health care are subject to the same rules as businesses operating in other sectors of the economy with respect to things like anti-trust, ownership structure, pricing, contracting, payment, purchasing, taxation and reporting requirements?
- D. Does the proposal protect consumers from unreasonable charges?
- E. Does the proposal contemplate legal reforms that would encourage all participants to exercise good judgment?
- F. How does the proposal plan to determine whether current licensing, inspection and reporting requirements produce net benefits?

- G. Does the proposal contemplate legal structures that will protect providers from arbitrary and capricious peer reviews?
- H. Does the proposal reduce legal barriers to entry affecting hospitals, specialty hospitals, long-term care providers, in-store medical practices, insurers of all kinds, providers of professional services, drug and device manufacturers, and suppliers of drugs and medical equipment?
- I. Does the proposal contemplate the legal reforms that would be necessary to encourage people who wish to create charity care clinics to do so without risking their personal assets?

IV. Does the proposal promote the use of economically efficient subsidies designed to maximize the general welfare?

- A. Does the proposal reform Medicaid?
 - (1) Do Medicaid subsidies accrue to individual patients rather than to providers?
 - (2) Can individual Medicaid patients spend the money that they receive at the provider of their choice? Can they purchase necessary supplies and services from the supplier of their choice?
 - (3) Does the proposal contemplate regulatory reform that allows the program to develop regulations and programs that treat different Medicaid populations according to their needs?
 - (4) Does the proposal contemplate Medicaid reforms that encourage Medicaid clients to use their Medicaid benefits wisely?
 - (5) Does the proposal include public access to Medicaid financial data so that amounts paid to providers, vendors, consultants, administrators, contractors, overseers, investigators, tax collectors, auditors and so on, as well as the purpose of the expenditures, can be clearly discerned?
 - (6) Does the proposal provide ways to discriminate between—and effectively manage—financial arrangements for people in legitimate need and those who take unfair advantage of subsidized and safety net programs?
 - (7) Does the proposal ensure that taxpayer-funded services will be provided only to eligible persons for eligible services?
 - (8) How will the proposal ensure that taxpayer-funded services are not provided to deceased persons, persons with fraudulent identification, nonresidents, persons not meeting financial requirements, illegal aliens, and so on?
 - (9) What penalties will be assessed for those who try to defraud the system by faking evidence of eligibility?
 - (10) What mechanisms in the proposal are designed to ensure that payment for taxpayer-funded services is actually rendered?
 - (11) How does the proposal contemplate providing medical care for people who, by reason of incapacity or simple stubbornness, do not comply with administrative requirements?
 - (12) Will the subsidies contemplated by the proposal encourage or crowd-out private mechanisms for financing medical services?

- (13) Do the way subsidies are distributed in the proposal deepen the state's "low-wage trap" by imposing effective marginal tax rates on low-income people trying to work their way out of dependency?
- (14) How does the proposal plan to distinguish between essential and non-essential health care services?
- (15) How does the proposal ensure that taxpayer-funded programs provide good value for the money spent?
- (16) Given that funds for taxpayer-funded programs are limited, how will the proposal manage the trade-offs that are necessary in a resource constrained subsidy program?
- (17) How does the proposal propose to measure the effectiveness of taxpayer-funded subsidy programs?
- (18) How does the proposal plan to determine the type and level of subsidies?

V. Programmatic considerations

- A. Does the proposal have a sunset provision?
- B. How does the proposal plan to measure whether it is a success?
- C. What trigger mechanisms automatically sunset the proposal in the event of budget excesses or poor performance?

APPENDIX B

Principles for Successful Reform and Specific Recommendations for the State of Colorado

Changes in the health care delivery system must, of simple necessity, be considered comprehensively but implemented in phases. Here are some of the recommendations that we believe should be considered.

1. As government assistance forms the basis for most fee schedules, including private insurance, submit Medicaid and CHP+ to true reform. Use the Section 1115 and HIFA waiver system to institute greater flexibility and innovation within the delivery system of these programs so that existing dollars can be optimized. Use these dollars to purchase private health care coverage, except in the cases of the most sick and vulnerable for which dedicated funds (medically needy) are established. Revise the benefit schedule to more realistic coverage levels. Permit and expand programs like Consumer Directed Attendant Support that incent people to use their health care dollars wisely;

2. Attack waste, especially that caused by government regulation. The area of duplicative services offers an excellent opportunity for collaboration as one point of departure.

3. As the above processes are underway, reform of the current regulatory and administrative system that oversees the private health insurance market must be completed to achieve the lowest possible costs of compliance, and to ensure that available premium dollars are optimized for health care delivery. A list, without discussion or any particular order, is provided below. It primarily concentrates on regulatory reforms that the state can affect that will lower premium costs by reducing administrative overhead. There are a few suggestions that will also increase the competitiveness of the health care market.

1. Reconsider state regulations that require insurers to charge the same premium whether policies cover 1 or 12 children. Right now, policies are priced at 2.8 to 3.2 children per family; people with fewer children, particularly single mothers with one or two children, pay more per child than others.
2. Maternity coverage should not be mandated for people who do not need it.
3. Colorado should make sure that waiting periods in its laws harmonize with federal law. Harmonization will decrease administrative overhead.
4. Non-network physicians (generally specialists like radiologists and anesthesiologists) get paid whatever they charge under network adequacy laws in order to protect the individual policyholder. As a consequence, overall rates for non-network care are passed along in the overall rate structures (millions of dollars per year) and premiums go up. Colorado law should be changed to allow negotiated networks in network facilities — that is, any provider giving service in that facility should only be paid reasonable and customary charges, which would allow lower insurance policy premiums, thus favoring policyholders.
5. Hospitals are protected from the “general contractor” rule by allowing physicians “privileges” to practice in their facilities (related to number 4). In many markets general contrac-

tors are responsible for all subcontractors. Hospitals grant privileges to physicians and other providers but do not control in-facility charges and practices. Changing this rule should be studied.

6. A recent statute requires private policies to pay for court-ordered mental health treatment. Courts are not accountable for the costs that they impose on others. The legislature should revisit this.
7. A recent statute requires that private policies pay for self-inflicted injuries due to the influence of alcohol and controlled substances. This drives up costs for responsible policyholders, and should be revisited by the legislators.
8. Insurance mandates should be revisited. In 2007 Colorado had 46 mandates. Arizona had 29, Indiana had 34 and Kansas had 37.
9. Reconsider the mandate requiring private policies to pay for early childhood disability evaluation.
10. State law allows small groups under 15 to self-insure for maternity; however, Colorado's Department of Insurance interprets a 1980s-era lawsuit (Budde) in a way that effectively prohibits small groups from doing so. A close reading of the decision makes this regulatory stance questionable, but the current effect is higher premium pricing for all small groups.
11. Consider eliminating the statute that prohibits list billing, allowing employers to collect premiums for employees' individual insurance at the same time they collect payroll taxes, retirement deductions, charitable payments and other payroll deductions.
12. Reconsider the statute rescinding rating flexibility for small groups. This increases the effect of the community rating straitjacket and increases premiums.
13. Examine Department of Insurance regulations that deviate from the National Association of Insurance Commissioner standards, which are intended to decrease administrative costs by increasing uniformity across states.
14. Reconsider regulatory restrictions on solving the retro term problem. Carriers require that employer groups give notice of termination, generally 31 days. Carriers usually supply employers with renewal notices 30 to 60 days before a renewal. Employers shocked by a huge price increase generally do not have time to shop around for new coverage and get it in place in the time left and end up paying for a month or more before they can switch policies.
15. Reconsider state regulations for continuation of insurance. They are not the same as COBRA, which causes significant administrative problems.
16. Reconsider regulations requiring that men and women be charged the same amounts regardless of their use of health care. Men cost less than women from roughly age 18 to age 50. After age 50 they cost more. Premiums should reflect this to effectively communicate differences in health care usage to policyholders.

17. State law prohibits short-term medical plans in excess of 6 months, with a limit of 2 per 12-month period. Reconsider those limits.
18. Common ownership restrictions create excess administrative costs, and loss of opportunities to create larger risk pools.
19. Consider reforms of regulations that create fragmented risk pools.
20. Reconsider state statutes making it illegal for physicians to have financial stakes in specialty hospitals. As physicians are highly qualified to invent better delivery models, prohibiting them from doing so limits competition and innovation. Concerns about conflict of interest can be handled with disclosure requirements. Also reconsider insurer prohibitions on reimbursement arrangements with physician or investor owned alternative care facilities like ambulatory surgery centers. There have been cases in which hospitals tell insurers that they will not be in a network unless insurers agree to limit outpatient surgery to the hospital day surgery center.
21. Consider allowing insurers in the individual market to offer mandate-free or mandate-light insurance policies, perhaps on an experimental basis of a few hundred or few thousand policies per year, or, alternatively, to those policyholders with HDHL/HSA policies.
22. Consider allowing Colorado residents to purchase health insurance from any insurer authorized to do business in any state, not just those licensed in Colorado.

Once government assistance programs and payments are brought into line, once waste within the system is properly addressed, the private coverage system will adapt to the new, more efficient realities of the overall health care delivery system, resulting in stable and relatively lower costs. In addition, the private coverage system will further adapt and innovate, bringing products to consumers that are more sensitive and useful, as well as being more cost effective.

APPENDIX C

How the Lewin Group Models Health Insurance Reforms

The Colorado Commission hired the Lewin Group to model its health reform proposals. The Lewin Group has developed a specialty model that looks at health spending with a 1990s perspective and can be adapted to various initial conditions with the creation of a synthetic population. In its June 2007 meeting, the Commission listened to a presentation of the baseline estimates developed using the Lewin model. Commissioners immediately began to view Lewin as an expert source of policy information. This effect was so pronounced that it can be fairly reported that the choices of which proposals to send forward for modeling were based on the briefing received from Lewin.

The numbers developed by Lewin are those against which the costs of the health care reforms selected for study by the Commission will be compared. At the outset, the Lewin group warned the Commission that it could not model the broader, long-term economic impacts of various health reforms on such things as earnings or job losses. It also warned that it could not forecast health care shortages or waiting lists that might be created by various reforms.

Since relatively little is actually known about health insurance and health spending in the Colorado population, the Lewin model creates a synthetic population based on some known facts about the Colorado population and puts that population through its paces based on general assumptions about how various population segments will change their behavior in response to different policy requirements.

Models may accurately predict future results if the synthetic population is an accurate representation and assumptions about costs and individual behavior in response to change are accurate. It should be noted that the baseline estimates made for Colorado appear to make a number of choices that may overstate the uninsured population.

The following discussion gives a sense of the errors that can be introduced in modeling, and why models must always be thoroughly checked against common sense and the real world. It outlines some of the issues raised by Lewin documents that describe the development of the Commission's baseline estimates — the modeling estimates against which projected outcomes for the selected reform plans will be compared.

Like any other model, the one used by the Lewin Group has strengths and weaknesses, and the cost and benefit estimates it produces must be placed in proper perspective. For policy purposes, the Lewin estimates share three important limitations with almost all other models. Although they provide valuable information about how policy changes might interact, their applicability to the real world is limited for the following reasons:

1. Model estimates reflect conditions at a specific time and generally assume instant adjustment to new conditions. The long-term effects of some proposed actions cannot be considered, nor can cost estimates account for changes that might occur over time. These could include significant price changes that increase or decrease the costs of specific policies. This makes the models much less reliable for mid- or long-term cost projections than for the short term.

2. The cost projections assume that every aspect of a proposal is put into place at the same time. They do not apply to policies that are implemented one piece at a time.
3. Lewin informed the Commission at the outset that it could not model shortages created by inappropriate pricing. It also does not model broader economic effects — such as the effect of tax increases on employment and earnings.

The administrative costs assumed for private insurers are too high. In one case, a Lewin presenter said that the administrative costs for individual insurance products were as high as 44 percent. The administrative costs more commonly cited in Lewin written materials were in the range of 34 percent to 35 percent, based on data from the Department of Insurance. Such data typically view administrative costs as the difference between revenues received and benefits paid. Everything that is not a benefit payment is an administrative cost. This includes profits, programs that generate savings on health care (and therefore reduce benefit payments), and fraud control that reduces benefits payments. For individual policies, all administrative functions are included in the premiums. For employer group policies, the difference between premiums and benefits payments would not include all of the additional human resource costs that companies incur to run their insurance plans. The authors of this minority report contacted 12 well-known insurance carriers during its preparation; these insurers reported that their administrative costs for individual policies ranged from 15 percent to 23 percent.¹

Due to data limitations, the model relies on small samples that may not represent Colorado. The detailed estimates of Colorado health spending and insurance coverage depend on 2004 Medical Expenditure Panel Survey (MEPS) data. When the MEPS sample was redesigned in 2004, MEPS expected roughly 560 responses from Coloradans in the private sector. No one knows how those 560 people would self-select for participation. Perhaps they are more likely to have time on their hands because they are in poor health and miss more days of work or work less, perhaps not.

As the small number of Colorado MEPS survey participants provides severely limited information about conditions in Colorado, the Commission model creates a baseline Colorado population using MEPS estimates for the western United States, including California. These MEPS estimates are used to estimate household spending, spending by military personnel and veterans, out-of-pocket spending, the cost of employer-sponsored insurance, retiree premiums for employer-provided insurance, and spending on state and local government employees.

Although Lewin used generally accepted methods to account for Colorado characteristics by weighting the western U.S. results, the weights chosen may not accurately reflect differences in the use of health care. For example, Lewin weighted the MEPS results to account for the fact that the California population is 25 percent Hispanic while Colorado is only 18 percent Hispanic. But simply being Hispanic is a crude measure of health care utilization. For example, for those over 35 years old, the diabetes-related mortality rate varies from 251 per 100,000 Mexican-Americans to 204 per 100,000 for Puerto Ricans and 101 per 100,000 for Cuban-Americans;² asthma prevalence varies from 13.2 percent for Mexican-Americans to 23 percent for Cuban-Americans;³ birth rates range from 105.1 births per 1,000 women of Mexican origin to 49.3 per 1,000 for Cuban women;⁴ and Hispanic immunization rates vary by area or origin.⁵ Absent other controls, classification as Hispanic would also not account for the large difference in public program participation between those who have recently moved to the United States and those who have been here for several generations.⁶

The method chosen to estimate the number of uninsured likely produces overestimates.

Lewin bases its estimates for the number of uninsured in Colorado on the March Current Population Survey (CPS), pooled from 2004 to 2006 to provide a larger sample. For a variety of technical reasons, it is generally agreed that the CPS overestimates the number of uninsured. In part, it is because respondents appear to report their insurance status at the moment they are questioned rather than for the whole year.⁷ The differences between CPS estimates and those of other surveys can be large.

A 2004 comparison of CPS and Survey of Income and Program Participation (SIPP) estimates found that the CPS estimate of the uninsured was 8 percent higher than the SIPP estimate.⁸ In 1998, the Wisconsin Family Health Survey estimated that 4 percent of Wisconsin residents were uninsured for an entire year. The CPS estimate for that year was 11.8 percent.⁹ The state of Wisconsin believes that the Family Health Survey is more accurate. For the baseline estimate of Colorado uninsured, the Lewin model took the CPS estimates and combined them with Colorado Medicaid enrollment data to estimate the “real” number of uninsured.

It then reduced the number of Colorado uninsured from 758,800 to 562,800 people to account for the Medicaid undercount associated with the CPS. Saying that it “estimates that there were another 506,800 people who were uninsured for part of year [*sic*],” Lewin added this to its estimate of 562,800 to arrive at a figure of 1,069,600 people uninsured at any point in the year. Further calculations provide an estimate of 785,200 people uninsured in any given month, or 17.2 percent of the Colorado population.

The effort to estimate the number of uninsured on a monthly basis is due to the fact that Medicaid enrollment is reported monthly. Obviously more people will be uninsured in any given month than over an entire year. But someone who is uninsured for a month or two in a year does not face the same difficulties as someone who is uninsured due to chronic illness. Judging policy by the elimination of everyone who was ever uninsured may lead to distorted policy by favoring expensive measures to take care of large groups when in fact a much smaller group is in real need of assistance. It also makes comparisons subject to errors introduced by various adjustments; other data used in the baseline estimates, like that from MEPS and the employer surveys, are on an annual footing. As a check, note that the 2005 CPS estimate for the uninsured in Colorado for 2003-2005 was 16.6 percent \pm 1 percent.¹⁰

Odd assumptions about administrative costs almost certainly overstate the cost savings from centralizing control. The Lewin model makes various assumptions about cost allocations. These depend heavily on assumptions about administrative costs. For example, 13 percent of total hospital costs are attributed to administration; this number is based on conversations with the hospital industry. To divide facilities costs into administrative and nonadministrative functions, the baseline numbers allocate 13 percent of all expenses for plant maintenance, housekeeping, depreciation, and leasing and rental expense to administrative costs.

The physician administrative costs used in the Lewin model are based on a voluntary survey of 335 physician practices conducted by the Medical Group Management Association. Most of those who respond to the survey are members of the MGMA. Typical MGMA members are specialty groups of 3 or more physicians. The MGMA provided one of the speakers invited to address the Commission. It sells software and a variety of other services.

Lewin documents suggest that it used a subset of the 335 responses in developing baseline numbers for the Commission. Its June 15 report to the Commission says, “We used the distribution of operating costs for non-hospital or IDS (Integrated Direct Service) multi-specialty practices” in the Western region. Based on whatever those cost numbers were, Lewin assumed that 10 percent of nurses’ time was administrative. Physician administrative expense was determined by “allocating costs to expense categories not directly attributable to providing patient care.” The document also says, “building and furniture expenditures were attributed to administrative functions in proportion to the allocation of other physician costs to administrative functions (approximately 35 percent).” So, if a physician rents an office to see patients, 35 percent of his rent is allocated to administrative costs. Other examples of physician costs attributed to administration in developing the Commission baseline data include medical record costs, employee staff benefits, general administration, information technology expenses, expenses for furniture, housekeeping and insurance premiums.

Other difficulties include determining hospital cost ratios. The hospital information used in the Commission model is from a databank maintained by the Colorado Hospital Association. The data set includes “general, financial and utilization information at the facility level for 62 Colorado hospitals in fiscal year 2004.” The problem is that the ratio of hospital payments to cost levels are calculated using hospital charges. Hospital charges often bear little relation to the prices actually paid. This is one of the major problems in health care that has been exacerbated by government programs and other forms of third party payment. As the Colorado Hospital Association points out in its reference guide,

“Charity care, bad debt, Medicare and Medicaid underfunding are defined below in terms of charges. Charges reflect expenses for providing care, plus an amount for underfunded and unpaid care and a margin for capital replacement, principal payments on long term debt, and other financial needs. Charges within a hospital must, by federal law, be the same for all patients for the same service. What a hospital actually collects can be quite different.”¹¹

Interpreting reported hospital charges is also difficult, given that hospitals actively manage their financial reports. For example, there is evidence that nonprofit hospitals adjust discretionary spending and accounting accruals to maintain their earnings in a range just above zero.¹²

Employer behavior and workforce data are limited and date as far back as 1991. The Lewin model uses the survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET) to model employer behavior. In 2005, the survey telephoned 2,013 firms nationwide, with a response rate of roughly 50 percent. The survey estimates that 60 percent of the firms employ 3 to 9 workers. Firms with fewer employees are not represented because the survey sample was drawn from a Dun & Bradstreet list of employers with three or more workers.¹³

In 2004, the Statistics of U.S. Businesses from the Census Bureau reported that 79 percent of Colorado firms had 9 or fewer workers, including 16 percent that had no employees at all.¹⁴ These numbers suggest that the data used in the Lewin model may not accurately reflect the Colorado business climate.

To create workforce statistics that are ultimately used to predict the amount employers will save on health spending in the various reform proposals, the Lewin model statistically matches each MEPS household worker to the HRET firms. But some detailed information that affects health insurance

coverage — like age, sex, coverage status, policy type and wage level — is not covered in the HRET survey. For “detailed” information on employer workforce, the Lewin model uses data from the 1991 Health Insurance Association of America employer survey data.¹⁵ This adjustment is a reach; using these data is equivalent to assuming that the Colorado population and economy have remained fairly static in the 16 years since 1991.

Data specifying individual insurance choice predate the introduction of HSA/HDHP policies and rely on 1987 to 1997 CPS data. In evaluating reform plans, the Lewin model estimates things like the number of people who drop private coverage to take up state coverage, the number of people eligible for Medicaid who actually enroll, how employers and employees respond to changes in the cost of insurance, and how employers decide to provide coverage using an unspecified “multivariate analyses.” Some of the parameters controlling this analysis are based on the 1997 Robert Wood Johnson Survey of Employer Characteristics and 1996 MEPS data on people offered coverage through an employer. Individual decisions to purchase individual coverage are modeled using an unspecified multivariate analysis of the likelihood that an individual will purchase coverage from the 1987-1997 CPS data. Premiums are imputed based on employer survey data. Needless to say, there is no room in these estimates for the effect of individual high-deductible plans on either spending behavior or coverage take up. The new HSA-qualified plans were not available in 1997.

Health spending projections are based on 2004 estimates and adjusted using 1998 Medicare data. Health spending projections by payer and type of service are based on 2004 estimates from the State Health Expenditure Accounts developed by CMS, using Census surveys of service establishments and state tax data. The FY 2004 amounts were extrapolated to FY 2007-2008 and adjusted to eliminate double counting and to exclude “non-health items that are included in national health spending estimates,” and were partly based on hospital financial reports. The projections were based on past ratios of the growth of Colorado health spending and U.S. health spending. Since state health expenditure accounts include spending by people from other states and exclude spending by Colorado residents outside of Colorado, the data were adjusted. The adjustment used is based on 1998 Medicare data. The bulk of the Medicare population is over 65.

Another example of an adjustment that is difficult to follow in the Lewin model is the apparent use of CPS survey data on average and marginal tax rates for the households used from the MEPS survey. Why this was done is unclear, as MEPS contains significant income data in its own right. Those income data match well with the CPS results. About 22 percent of MEPS income supplement data is missing wages, which are imputed from the employment section.¹⁶

The estimates of the illegal population in Colorado are significantly less than those used by other sources. The original Lewin baseline estimates were 167,000 noncitizens among 785,200 Colorado uninsured. Using the 2000 Census data and CPS data from 2002, the Urban Institute estimated that there were 175,000 to 200,000 illegal aliens in Colorado.¹⁷ The Center for Immigration studies used the 2005 CPS to estimate the illegal population in Colorado at 220,000, of whom an estimated 152,000 were uninsured. Including illegal aliens and their foreign and U.S.-born children under age 18, an estimated 183,000 are uninsured.¹⁸ In all, the Center estimates that a fifth of the uninsured in Colorado are illegal aliens. One fifth of the Lewin estimate of 785,200 is 157,040 people, which is 94 percent of Lewin’s estimate of the noncitizen uninsured.

Omitting estimates of illegal aliens in the uninsured population has implications for spending if a reform plan contemplates using federal Medicaid matching funds to defray Colorado health expenses. The reason is that Colorado cannot legally claim matching federal funds for nonemergency Medicaid health services provided to illegal aliens. Reform plans that use federal disproportionate share funds to pay for coverage extensions may also create significant problems for hospitals. The hospitals will still be required to provide services to illegal aliens under the Emergency Medical Treatment and Active Labor Act (EMTALA), but the disproportionate share funds intended to compensate them for this will have been diverted to other uses.

¹ Allan Jensen, personal communication.

² Chrystal A. S. Smith and Elizabeth Barnett, "Diabetes-related mortality among Mexican Americans, Puerto Ricans, and Cuban Americans in the United States," *Revista Panamericana de Salud Publica (Pan American Journal of Health)*, Vol. 18, No. 6, December 2005, pages 381-387.

³ Adam M. Davis et al., "Asthma Prevalence in Hispanic and Asian American Ethnic Subgroups: Results from the California Healthy Kids Survey," *Pediatrics*, Vol. 118, No. 2, August 2006, pages 363-370.

⁴ Paul D. Sutton and T. J. Mathews, "Birth and fertility rates for states by Hispanic origin subgroups: United States, 1990 and 2000," Center for Disease Control, Vital and Health Statistics Series 21, No. 57, May 2006. Available at http://www.cdc.gov/nchs/data/series/sr_21/sr21_057.pdf. Access verified February 19, 2008.

⁵ Guillermo A. Herrera, Zhen Zhao and R. Monina Klevens, "Variation in vaccination coverage among children of Hispanic ancestry," *American Journal of Preventative Medicine*, Vol. 20, No. 2, May 2001, pages 69-74.

⁶ For example, see George J. Borjas and Lynette Hilton, "Immigration and the Welfare State: Immigrant Participation in Means-Tested Entitlement Programs," *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996, pages 575-604.

⁷ For an example of the literature on this topic see Cathi M. Callahan and James W. Mays, "Estimating the Number of Individuals in the United States Without Health Insurance," U.S. Department of Health and Human Services, Working paper, March 31, 2005. Available at <http://aspe.hhs.gov/health/Reports/05/est-uninsured/report.pdf>. Access verified December 10, 2006.

⁸ Shailesh Bhandari, "People with Health Insurance: A Comparison of Estimates from Two Surveys," U.S. Census Bureau, The Survey of Income and Program Participation Report No. 243, June 8, 2004. Available at <http://www.sipp.census.gov/sipp/workpapr/wp243.pdf>. Access verified July 10, 2007.

⁹ Catherine A. Frey, "Wisconsin's Uninsured Population: How Low — 4% or 11.8%?" University of Wisconsin, Population Health Institute, Issue Briefs, Vol. 1, No. 1, March 2000. Available at http://www.pophealth.wisc.edu/UWPHI/publications/issue_briefs/issue_brief_v01n01.htm. Access verified July 11, 2007.

¹⁰ "Health Insurance Coverage Status by State for All People: 2005 Not poverty universe: unrelated individuals under age 15 are included," U.S. Census Bureau, Annual Demographic Survey, Table HI06, 2005. Available at http://pubdb3.census.gov/macro/032006/health/h06_000.htm. Access verified February 19, 2008.

¹¹ "Reference Guide to Colorado Hospital Financial & Utilization Data 2002 & 2003," Colorado Health & Hospital Association, March 2005, page 12. Available at <http://www.chha.com/download/referenceguidenp.pdf>. Access verified July 10, 2007.

¹² See for example Andrew J. Leone and R. Lawrence Van Horn, "How do nonprofit hospitals manage earnings?" *Journal of Health Economics*, Vol. 24, July 4, 2005, pages 815-837.

¹³ Gary Claxton et al., "Employer Health Benefits 2005 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trust, 2005, pages 9-14. Available at <http://www.kff.org/insurance/7315/upload/7315.pdf>. Access verified July 11, 2007.

¹⁴ “Statistics of U.S. Businesses: 2004; All Industries Colorado,” U.S. Census Bureau. Available at <http://www.census.gov/epcd/susb/2004/co/CO--.HTM>. Access verified July 11, 2007.

¹⁵ “Attachment B: Summary Description of the Health Benefits Simulation Model (HBSM),” Lewin Group, January 29, 2007, page 5. Available at <http://www.lewin.com/NR/rdonlyres/F47554D8-3FC8-43A6-A929-A5868FA07E1A/0/BushAnalysisAttachmentBHBSM.pdf>. Access verified February 19, 2008.

¹⁶ This is discussed in *Attachment B: Summary Description of the Health Benefits Simulation Model (HBSM)* dated January 29, 2007, and distributed to the Colorado Health Care Reform Commission. The comparison of CPS and MEPS results is outlined in Jessica S. Banthin and Thomas M. Selden, “Income Measurement in the Medical Expenditure Panel Survey,” Agency for Healthcare Research and Quality, Working Paper No. 06005, July 2006. Available at http://207.188.212.220/mepsweb/data_files/publications/workingpapers/wp_06005.pdf. Access verified July 11, 2007.

¹⁷ Jeffrey S. Passel, Randy Capps and Michael Fix, “Undocumented Immigrants: Facts and Figures,” Urban Institute, Immigration Studies Program, January 12, 2004. Available at http://www.urban.org/UploadedPDF/1000587_undoc_immigrants_facts.pdf. Access verified February 19, 2008.

¹⁸ Steven A. Camarota, “Immigrants at Mid-Decade: A Snapshot of America’s Foreign-born population in 2005,” Center for Immigration Studies, Background, December 2005. Available at <http://www.cis.org/articles/2005/back1405.pdf>. Access verified February 19, 2008.

About the Author

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R. Allan Jensen was a commissioner on the Colorado Blue Ribbon Commission on Health Care Reform. Mr. Jensen has been an insurance broker for more than 16 years. His practice focuses on individual and small group health coverage, life insurance and seniors products, specifically Medicare and long term care. He previously worked in operations, marketing and sales in the homebuilding and commercial construction industries for 16 years.

Mr. Jensen has also served as the state legislative chair for the Colorado Association of Health Underwriters, as president of the Metro Denver Association of Health Underwriters, and as the Region VII legislative chair for the National Association of Health Underwriters. Jensen is a 1974 graduate of the Air Force Academy, and worked in the space systems field during active duty. He obtained his Masters degree in Public Administration from the University of Colorado in 1979.

About the NCPA

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy. The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, *WebMD* and the *National Journal*) as the “Father of HSAs.” NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the president made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. Health Savings Accounts now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and Blue-Cross Blue-Shield of Texas developed a plan to use money federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

Taxes & Economic Growth. The NCPA helped shape the progrowth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA’s proposal for an across-the-board tax cut became the centerpiece of President Bush’s tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* (“A Kinder, Gentler Flat Tax”) advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, *Wealth, Inheritance and the Estate Tax*, completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Actually, the contribution of inheritances to the distribution of wealth in the United States is surprisingly small. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. In his letter, Sen. Frist said, “I hope this report will offer you a fresh perspective on the merits of this issue. Now is the time for us to do something about the death tax.”

Retirement Reform. With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study *Ten Steps to Baby Boomer Retirement* shows that as 77 million baby boomers begin to retire, the nation’s institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are completely unfunded. Private sector institutions are not doing better — millions of workers are discovering

that their defined benefit pensions are unfunded and that employers are retrenching on post-retirement health care promises.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into the companies' 401(k) plans, automatic contribution rate increases so that as workers' wages grow so do their contributions, and stronger default investment options for workers who do not make an investment choice.

The NCPA's online Social Security calculator allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

Environment & Energy. The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

Educating the next generation. The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

Promoting Ideas. NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from Burrelle's, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA

"The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways." –Newt Gingrich, former Speaker of the U.S. House of Representatives

"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like health savings accounts. These things work, allowing people choices. We've seen how this created America." –John Stossel, co-anchor ABC-TV's 20/20

"I don't know of any organization in America that produces better ideas with less money than the NCPA." –Phil Gramm, former U.S. Senator

"Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people." –Tommy Thompson, former Secretary of Health and Human Services

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