



Statement of

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on

**MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES:
Saving Money, Saving Lives**

Energy & Commerce Subcommittee on Health
United States House of Representatives
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Mr. Chairman and members of the Subcommittee, I offer these comments for your consideration as you debate options for increasing the quality of health care and lowering the cost. I represent the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

To confront America's health care crisis, we do not need more spending, more regulations or more bureaucracy. We do need people, however, including every doctor and every patient. Every American must be free to use their intelligence, their creativity and their innovative ability to make the changes needed to create access to low-cost, high-quality health care.

I. Free the Doctor

Doctors today are forced to practice medicine under an outmoded, wasteful payment system designed for a different century. They should instead be given access to payment systems available to other professionals.

Problem: Typically, doctors receive no financial reward for talking to patients by telephone, communicating by e-mail, teaching patients how to manage their own care or helping them be better consumers in the market for drugs. In fact, doctors who help patients in these ways will end up with less take-home pay. To make matters worse, as third-party payers suppress reimbursement fees, doctors are increasingly unable to perform any task that is not reimbursed.

Solution: Let Doctors Be Doctors. In Medicare and Medicaid, it should be as easy as possible for providers to get paid in better ways. We should be willing to reward doctors who raise quality and lower costs — including improving patient access to care, improving communication and teaching patients how to be better managers of their own care. What is needed is not pay-for-performance, but performance for pay — with ideas and proposals coming from the supply side of the market (which is more knowledgeable about potential improvements than the demand side).

Any doctor should be able to propose and obtain a different reimbursement arrangement, provided that (1) the total cost to government does not increase, (2) patient quality of care does not decrease and (3) the doctor proposes a method of measuring and assuring that (1) and (2) have been satisfied.

In the *Handbook on State Health Care Reform*, for example, the NCPA proposed a radically different way to pay for chronic care, with the state paying a flat monthly fee to cover “fixed costs” (*e.g.*, coordination of care, maintenance of electronic medical records) and patients paying, say, from Health Savings Accounts, for the “variable costs,” including paying doctors for their time (*e.g.*, face-to-face, e-mail and telephone consultations). Practitioners will no doubt think of many variations and improvements on this idea.

Problem: All too often providers face perverse incentives. When they make changes that raise quality and lower costs, their income goes down, not up.

Example: Geisinger Health System in central Pennsylvania gives heart patients a “warranty” on their surgeries. Patients who have to be readmitted because of complications pay nothing for the second admission. Yet in providing higher quality and lowering patient costs, Geisinger loses money. That’s why other hospitals do not follow its example.

Example: Studies show that if every patient went to the Mayo Clinic for health care, we could lower the national health care bill by one-fourth — and quality would improve. If everyone went for care to the Intermountain Hospital System in Salt Lake City, we could lower our health care costs by one-third — while improving quality. Why don’t other hospitals copy these exemplars of low-cost, high-quality care? Because they would be severely penalized financially under the current system.

Solution: Let Hospitals Be Hospitals. Facilities that figure out how to lower patient costs, raise quality and offer warranties and other guaranties should be rewarded for doing so — just as they would in any other market. Accordingly, the same three reimbursement rules proposed for doctors above should also apply to hospitals.

Problem: Entrepreneurs are creating new products to meet needs not being met by traditional health insurance. For example, people can pay with their own money for telephone and e-mail consultations. They can purchase blood tests via the Internet and get results in 24 hours. They can get low-cost care with very little waiting at walk-in clinics in shopping malls. Yet all too often these services are hampered by outmoded, unnecessary government regulations. Amazingly, doctors are prohibited from owning and operating walk-in clinics that refer patients to their regular practices!

Solution: Let Entrepreneurs Be Entrepreneurs. We should welcome and encourage new ways of meeting patient needs, rather than stifle these efforts with unnecessary, outmoded laws and regulations. As with providers and facilities, promising innovations should be expedited and approved quickly. For example, walk-in clinics that charge half as much and match the quality of traditional care, with electronic medical records and electronic prescriptions to boot, should be approved outright.

II. Free the Patient

Patients also suffer when payments to doctors and hospitals are based on outmoded formulas. Whereas suppliers compete to meet customer needs in almost every other market, this happens all too rarely in health care.

Problem: Many patients have difficulty seeing primary care physicians. All too often they turn to hospital emergency rooms where there may be long waits and where the cost of care is much higher. When they do see doctors, all too often patients get inadequate information. The problem is made worse by the inability to communicate by telephone or e-mail.

Solution: Patient Power. We need to explore new ways to empower patients — especially the chronically ill, allowing them to manage more of their own care and more of their own health

care dollars. Also, patients should be able to purchase services that are not paid for by traditional health insurance, including telephone and e-mail consultations and patient education services.

Example: Studies show that diabetics, asthmatics and other chronic patients can manage their own care as well as or better than conventional physician care and at lower costs. Yet to do this patients need training, easier access to information and the ability to purchase and use in-house monitors.

Example: More than half the states have “Cash and Counsel” programs for homebound, disabled Medicaid patients — allowing them to manage their own health care dollars and hire and fire the people who provide them services, instead of having these decisions made by an impersonal bureaucracy. Patient satisfaction in these programs is almost 100 percent.

III. Free the Employees

Our health insurance system evolved at a time when many workers expected to work for the same employer for their entire work lives. Clearly, that assumption is no longer valid.

Problem: When employees switch jobs, they are usually forced to switch insurance plans. This often means a switch of doctors, which means no continuity of care. Also, their new insurance may not have the same benefits as the original. To make matters worse, many employees are trapped in jobs they cannot leave because they cannot afford to lose their health insurance.

Solution: Personal and Portable Health Insurance. We should move to a system in which employees can take their health insurance with them when they travel from job to job. Transition to a new system may take many years. A good place to start is with baby boomers who retire early.

Problem: People who do not get health insurance from an employer must pay for it with after-tax dollars, making insurance as much as 50 percent more expensive.

Solution: Tax Fairness. People who obtain health insurance should enjoy the same tax relief, regardless of how the insurance is purchased.

IV. Free the Employer

Employers are also trapped in a system designed for a different age.

Problem: In ways that are sometimes subtle and sometimes not so subtle, too many employers are trying to avoid hiring employees (and employee dependents) with high health care costs, much like a game of musical chairs.

Problem: By default, employers have been put in the position of having to manage their employees' health care costs — an activity for which most have no experience or expertise. While some large employers do an adequate job, small employers are incapable of doing it well.

Solution: Personal and Portable Insurance. Portable insurance would be a boon to employers as well as employees. Employers could make a defined contribution to each employee's health insurance; yet the insurance would be owned by the employees and travel with them on their journey through the labor market. In an ideal world, employers should be able to hire employees based solely on their ability to produce, irrespective of expected medical costs.

Example: The United Mine Workers, NFL football players and many other workers have better arrangements. Although employers pay all or most of the health insurance premiums, the health plan is largely independent of any particular employer and coverage is fully portable — traveling with employees whenever they switch jobs.

V. Free the Nontraditional Workplace

Most of our labor law, tax law and employee benefits law was enacted years ago and was based on the assumption that employees would be full-time workers, typically with a homemaker telecommuting. Today, one-third of the workforce consists of part-time workers and independent contractors. Many are telecommuting from their own homes. These changes are partly the result of the most important economic and sociological change of the past half-century: the movement of women into the labor market.

Problem: Two-earner couples are common in the labor market. They need employee benefits, including health insurance, but they don't need duplicate benefits. An employee covered by a spouse's health plan should be able to choose higher wages rather than an unnecessary second health plan. Yet today employers cannot give her that option.

Problem: Many part-time employees face the opposite problem. They would willingly take less pay if they could be enrolled in their employer's health plan. Yet employers generally are not allowed to give employees this option either.

Solution: Flexible Employee Benefits. Public policy should be on the side of helping people meet their needs rather than creating bureaucratic obstacles. Employers and employees should be free to adjust their employee benefit policies to meet the needs of a changing workplace.

VI. Free the Insurer

Like doctors, patients, employees and employers, insurance companies are also trapped in a dysfunctional system.

Problem: All too often insurers operate under regulations that encourage them to avoid the sick and attract the healthy. Even worse, they may face incentives to under-provide care to the sick and over-provide to the healthy. These perverse incentives are as bad for the insurers as they are for the patients.

Solution: A Market for the Care of Sick People. We need to encourage insurance markets in which health plans specialize in various conditions — especially chronic illness. Plans should

compete to see who can better solve the needs of the people with the most severe health problems.

Example: In the Medicare Advantage program the federal government uses a highly sophisticated payment system that pays higher premiums for sicker, costlier enrollees. As a result, patients with health problems are just as attractive as healthy people to insurers. In fact, some health plans specialize in insurance for people with multiple health problems.

VII. Free the Uninsured

One reason why there are so many uninsured in America is that we encourage people to be uninsured.

Problem: Most uninsured people do not have the opportunity to obtain tax-subsidized employer-provided health insurance. As a result, if they buy insurance on their own they must do so with aftertax dollars. In this way, the tax law discourages private insurance.

Problem: If the uninsured need medical care and can't pay their bills, they receive free care — an amount equal to about \$1,500 per uninsured person per year — or \$6,000 for a family of four. Since these funds can generally not be used to purchase private insurance, free care programs around the country encourage people to be uninsured.

Solution: Insure the Uninsured. We can use money already in the system to give people who would otherwise rely on the free care safety net a tax subsidy to purchase private health insurance instead.

VIII. Free the Kids

Many in Congress want to push children into a State Children's Health Insurance Plan (S-CHIP), paid for by taxpayers. Both the children and the taxpayers would be better off if kids were enrolled in their parent's private health insurance plans instead.

Problem: Studies show that every time government spends an extra \$1 on S-CHIP, private insurance contracts by 60 cents. Either families drop their private insurance in order to take advantage of free government-provided health insurance or employers drop coverage and pay higher cash wages instead — knowing that free health insurance is an option for their employees. Because of a very high crowd-out rate, S-CHIP expansion is very costly to taxpayers and produces small social benefits. To make matters worse, children are leaving private plans where they have access to a broad array of doctors and facilities to enroll in public plans where their access is often no better than the access of the uninsured or Medicaid enrollees.

Solution: Private Insurance for Children. Instead of encouraging people to drop private coverage for a public plan, we should reverse the incentives: use S-CHIP money to encourage parents to enroll their children in their employer's plan or another plan of the parents' choosing.

IX. Free the Parents

Under the current system, a child could be enrolled in S-CHIP, a mother could be enrolled in Medicaid and a father could be enrolled in an employer's plan. Medical outcomes are likely to be better for all three if they are in the same health plan.

Problem: As in the case of S-CHIP, Medicaid has a very high crowd-out rate. Public dollars substitute for private dollars. And access to care inevitably diminishes when people make the transition.

Solution: Private Insurance for Low-Income Families. If we truly want universal access to health care, low-and moderate-income families must be able to see the same doctors and enter the same facilities as other citizens. That will never happen unless they participate in the same health insurance plans as other citizens. Instead of cordoning people off in a plan that underpays providers and rations care by waiting, we should use Medicaid and S-CHIP funds to subsidize private health insurance for all who want it.

X. Free the Grandparents

More than 40 years ago our country decided to segregate seniors into a separate health insurance system called Medicare. In the beginning Medicare copied the standard Blue Cross plan of the day. With the passage of time, however, Medicare lagged behind the improvements in other insurance products.

Problem: The basic Medicare package (Parts A & B) is distinctly inferior to the kind of insurance most other Americans have. (It is even inferior to coverage for poor families under Medicaid.) For example, seniors are exposed to far more out-of-pocket risk and they do not have coverage for preventive care. Shockingly, the basic Medicare package will pay for the amputation of diabetic's leg, but it will not pay for drugs that would have made the amputation unnecessary.

Problem: To fill the gaps in their basic coverage, most seniors obtain Medigap coverage — which means that must pay two premiums to two plans. Even then, seniors usually do not have the coverage for drugs that most nonseniors have. So they must pay a third premium to a third plan (Medicare Part D) to get the same total coverage other people obtain by paying a single premium to a single plan. Paying three premiums to three plans is wasteful. Studies show that if the first two premiums were paid to a single, comprehensive health plan, the third premium seniors are paying would be unnecessary.

Problem: Even with comprehensive coverage, Medicare is still the least modern of all the health insurance plans. Medicare is the least likely to pay for telephone or e-mail consultations or for health care services obtained outside of the country. It also refuses to pay for convenient care in walk-in clinics in drugstores and shopping malls, although even Medicaid is beginning to pay for these services for low-income families in some states.

Example: The Medicare Advantage program has been a highly successful innovation. For only a modest premium (in addition to the Part B premium) and in some cases for no additional

premium, seniors are able to enroll in comprehensive health plans similar to the health insurance most nonseniors have. Compared to traditional Medicare, these seniors get about \$825 of additional benefits per year.

Solution: Access to the Full Insurance Marketplace. Seniors who are happy with their current arrangement should be allowed to stay there. But millions of seniors could have more care and better care for less money if we expanded the range of options. Other citizens have access to PPO plans, Health Savings Account plans and other hybrids. Seniors need these same options as well.

Thank you for considering these comments.