

Health Care in Vermont: A New Prescription

*A pathbreaking agenda for consumer driven health insurance –
transforming health care systems – reforming provider liability –
and expanding personal responsibility for wellness.*

July 2004



An Ethan Allen Institute Report

Health Care in Vermont: A New Prescription

*A pathbreaking agenda for consumer driven health insurance –
transforming health care systems – reforming
provider liability – and expanding personal
responsibility for wellness.*

Contents

| | |
|--------------------------------------------------------------------|----|
| Executive Summary | 3 |
| How today's health insurance problem began | 4 |
| The aggravated cost shift problem | 5 |
| The health insurance market deteriorates | 5 |
| The Hogan Commission Report | 6 |
| Legislative Action 2001-2004 | 7 |
| Vermont's health care philosophy in 2004 | 9 |
| What these policies have produced | 10 |
| Fundamental Health Care Reform: Seventeen Steps | 11 |
| Sidebar: Ten Tools for Achieving Consumer Driven Health Care | 12 |
| Useful References for Health Care Policy | 16 |

This report was written by Ethan Allen Institute President John McClaughry, a member of the Vermont Senate from 1989 to 1992. Much of it is based on the Institute's report *Reviving Health Insurance in Vermont* (2000). The discussion of the CON process is adapted from the Institute's report *Creating Choices for Home Health Care Consumers* (2004). Both reports are available at www.ethanallen.org.

July 2004



Ethan Allen Institute

4836 Kirby Mountain Road • Concord, VT 05824

Phone: 802-695-1448 • Fax: 802-695-1436

E-mail: eai@ethanallen.org

Web page: <http://www.ethanallen.org>

Health Care in Vermont: A New Prescription

Executive Summary

The purpose of this report is to explain how Vermont's public policies on health care changed from 1984 to 2004, and the unhappy consequences of those changes. Chief among the consequences have been an aggravated state-caused cost shift to hospitals and doctors, resulting from state expansion of discount-entitled customers, and the serious deterioration of a once-strong health insurance market, mainly due to steps taken to rescue the state's only domestic health insurer, Blue Cross/Blue Shield of Vermont.

The report describes the Hogan Commission's efforts and the legislative action - and inaction - of 2001-2004. It summarizes the elements of Vermont's health care philosophy, a philosophy that will inexorably lead to a totally government-controlled health care system akin to that of Canada or Great Britain.

The report then argues for seventeen explicit recommendations for reform. Public policy should:

1. Put primary responsibility for wellness back to individuals
2. Intensify wellness education for consumers
3. Redefine the role of health insurance
4. Encourage wider use of Health Savings Accounts
5. Repeal community rating
6. Allow carriers to offer healthy lifestyle premium discounts
7. Roll back costly coverage mandates
8. Pay the true cost of Medicaid services
9. Convert acute-care Medicaid to an HSA-style program
10. Repeal the Certificate of Need process
11. Recapture unpaid medical bills through the tax system
12. Create a high risk pool for the medically uninsurable
13. Tighten tort liability standards for medical providers
14. Promote the purchase of long term care insurance
15. Develop and implement new health care information technology
16. Support the independent free clinics
17. Repeal wrong-headed policy statements in existing laws



Ethan Allen Institute

4836 Kirby Mountain Road • Concord, VT 05824

Phone: 802-695-1448 • Fax: 802-695-1436

E-mail: eai@ethanallen.org

Web page: <http://www.ethanallen.org>

How Today's Insurance Problem Began

Today's deepening Vermont health insurance problem dates back to events that began to unfold in 1984. It derives directly from the troubled history of the Vermont Hospital Service Corporation, better known as Blue Cross.

The story is a long and involved one, and has been told in detail elsewhere. [See references for Ethan Allen Institute (2000), Howard Leichter (1994), and Hamilton Davis (1999)]. The major events from 1984 to 2002 can be summarized concisely.

In 1984 the Vermont Supreme Court determined that the business practices and internal management decisions of Blue Cross/Blue Shield of New Hampshire and Vermont, were subject to intrusive regulation by Vermont insurance regulators.

The bi-state Blue Cross Blue Shield organization separated into two entities, each regulated by only one state government. The process of disentangling the data, assets and accounts into two separate companies produced major financial problems, and seriously bad publicity, for the new Blue Cross Blue Shield of Vermont.

In 1990, to stem a hemorrhage of nervous customers to competing private insurance carriers, Blue Cross, by the time technically insolvent, decided to push for legislation that would impose community rating requirement on its competitors in the small group market. Community rating, which Blue Cross had always practiced for philosophical reasons (and as justification for an exemption from the premium tax), prohibits a carrier from charging premiums that vary by the insurer's age, gender, location, occupation, or medical history.

The 1991 legislature enacted a community rating premium band of +/-20 percent, with no variation allowed for age or medical history. This imposed a sudden, large premium increase on groups dominated by young healthy insureds. Many plans were cancelled, and the insureds went off to buy coverage in the non-group or individual market.

That development led to a second law to community rate the individual market as well. This had the effect, eventually, of reducing the number of health insurance carriers in Vermont from 16 to two or three.

The 1992 law (Act 160) was the flagship of the political hopes of Vermont's young doctor-governor, Howard Dean. In addition to the community rating provisions, it dramatically expanded government control over hospitals, and created a Health Care Authority to propose two sweeping "universal coverage" plans to the 1994 legislature.

After spending nearly a million dollars, the Authority unveiled its two plans in late 1993. Gov. Dean rejected the Authority's version of his preferred "regulated multi-payer" plan. Sen. Cheryl Rivers, leader of the single payer forces, denounced the Authority's single payer proposal.

The 1994 House came to the brink of voting on at least two versions of a "universal access" plan. The effort dramatically collapsed on the House floor. Subsequently, to the outrage of Gov. Dean, conservatives and socialists on the Senate Finance committee joined to kill off the empty shell of "universal coverage" legislation on a 7-0 vote.

From 1994 on Gov. Dean and the legislature sought to move toward government controlled health care by the steady expansion of Medicaid, the means-tested federal-state program to provide health care for welfare families, aged, blind and disabled, and the "medically needy." Since 1989 lower income children aged 0-6 had already been served by Dr. Dynasaur. It was expanded

to ages 0-18, and the Vermont Health Assistance Plan instituted in 1995 to give Medicaid managed care coverage to, ultimately, children from families earning up to 300 percent of the Federal Poverty level (in 2004, around \$54,000). Gov. Dean's effort to include the parents of such children was rejected by the Clinton Administration.

The Aggravated Cost Shift Problem

One major and increasingly serious negative effect of Medicaid expansion has been the hospital and nursing home cost shift. This occurs when the government qualifies patients who must be treated by hospitals and nursing homes, but declines to pay the market price for their care. The provider must then recover the loss by shifting the cost to – in effect “taxing” – its other customers. This cost shift requires “private pay” patients – those covered by employer-paid or patient-paid insurance – to absorb the costs of government required cut-rate treatment of Medicaid eligible patients.

The cost shift theoretically applies to physicians as well, but few physicians are in a position to shift costs to other payers. Forty years ago the independent fee-for-service physician would adjust his rates informally depending on his patients' ability to pay. Thus the bills charged to affluent patients would cover a portion of care given free to the poor. But today most physicians are locked into payment schedules negotiated by Preferred Provider Organizations or HMOs. Once those schedules are fixed, a physician has little opportunity for making up the cost of Medicaid or Medicare underpayment by charging higher prices to others. Instead, more and more physicians and especially dentists are declining to accept patients for whom the government refuses to pay the full costs. By contrast it is illegal for a hospital to turn away a patient.

Both the federal Medicare program and the state Medicaid programs contribute to the hospital cost shift. Gov. Dean was fond of saying that Medicare is the major contributor and that Medicaid, whose expansion he has so avidly engineered, is a minor problem. Using AHS figures for 1998, the Medicare cost shift shortfall at Vermont hospitals was \$19 million, and that for Medicaid was \$16.5 million. But since Medicare spending in Vermont is 3.5 times as large as Medicaid spending, the percentage cost shift was much larger for Medicaid: 27.9 percent compared to 7.8 percent. Even this comparison is excessively favorable to Medicaid, because there is a controversy about whether the computation should credit the state for “DSH” reimbursements made to hospitals to pay them back for their payment of the health care provider taxes used to fund Medicaid, through a fiscal maneuver called “Mediscam” by its critics.

The Health Insurance Market Deteriorates

As Gov. Dean's steady expansion of Medicaid progressed, conditions in the private insurance market deteriorated rapidly.

In May 1997 Gov. Dean signed the mental health parity mandate (Act 25), requiring insurers to provide for mental illness treatment on the same basis as physical illnesses. Advocates claimed that parity would increase premium costs by only 3.4 percent, but were unwilling to add that cap to the legislation. Since mental illnesses are notoriously difficult to cure, parity can lead to an open-ended series of patient visits with very expensive mental health professionals (who not surprisingly lobbied heavily for the act's passage). Actuarial estimates for mental health parity range up to an additional 10 percent of premium costs, three times what advocates were willing to admit. The higher premiums mandated by Act 25 assure that more Vermonters and their employers will no longer be able to afford coverage.

In 1999 Gov. Dean signed a mandate for chiropractic (Act 16) – and soon after instructed the legislature not to think up any more costly mandates for him to sign.

In September 1999 BISHCA Commissioner Betsy Costle approved increases for Kaiser Permanente, Blue Cross, and MVP premiums on the order of 20 percent, starting October 1. A month later she announced that the +/- 20 percent rating band for individual and small group contracts would be terminated in 2000, giving Vermont 100 percent pure community rating.

By mid-2004, thanks mainly to community rating and guaranteed issue, only Blue Cross and for-profit MVP Health Insurance offer individual policies. This latter plan is allowed to rate by age, but not by medical factors.

Only three companies offer small group plans (Blue Cross, CIGNA, and John Alden). There are three managed care (HMO) plans: MVP, The Vermont Health Plan, and the Vermont Health Partnership, the latter two controlled by Blue Cross. In addition, there are association plans, where a large number of small businesses unite to buy coverage in bulk. Association plans are allowed to charge their members premiums based on claims experience, rather than community rating the entire pool. The coverage, however, must be bought from one of the Vermont-regulated carriers or HMOs.

The uninsured percentage, the Holy Grail of the Dean years, was 9.2 percent for 1992, according to the Current Population Survey of the U.S. Census Bureau. (This CPS figure is not entirely dependable because of small sample size, but Gov. Dean was pleased to cite it when it supported his policies.) In 2002, after a decade of expanding government intervention in health care and the forced exodus of private insurance companies, 10.3 percent of Vermonters (66,000) were uninsured.

One policy goal of the Dean era has been achieved. Vermont has become, after Tennessee, the state with the highest percentage of its population enrolled in state government health care programs, i.e., Medicaid: 18.1 percent (2002). According to Gov. Jim Douglas's 2004 budget message, the vastly expanded Medicaid program will produce a fund shortfall of \$245 million by 2009 unless dramatic steps are taken. Increasing copayments and eliminating coverage for dentures will not be enough to deal with this huge fiscal problem.

The Hogan Commission Report

In 2000 Gov. Dean appointed a Commission on Health Care Availability and Affordability, chaired by former AHS Secretary Con Hogan. Its report went to the legislature in January 2002. The very diverse membership of the commission (free market legislators, bureaucrats, and socialists) resulted in a report that gave something to everybody without producing a clear course of action for anybody.

The introduction appears to have been written by the socialist members: "We do not have a health care system in Vermont. No one is in control. No one is responsible for ensuring that high quality medical care is adequate for the needs of the public. No one ensures that medical charges are appropriate or that they are paid in full... There is no global budgeting" or "public accountability" for health care institutions.

After this declaration it would not have been surprising to read "Therefore, we (the government) must take control. Vermont needs a Health Care Czar who will make sure everybody gets all the high quality care the government thinks they need, all charges are appropriate, all budgeting is under government control, and everything not required is prohibited."

Instead, the report made a U-turn. It proceeded to deny that putting the government in charge of everybody's health care is a good idea. The commission (except for former Sen. Cheryl Rivers) rejected single-payer health care because it didn't believe government could manage it or pay for it, and that in any case there was no consensus for such an idea. The report also declined to support another popular socialist idea, price controls on pharmaceuticals.

Having completed this rhetorical about-face, the report made a number of important and useful observations and recommendations. Among them were:

- “The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government.”
- “Competition in health care and [insurance] coverage... tends to control costs, foster efficiency and maintain affordability”, and should be maximized.
- “Community rating [of insurance premiums] has the effect of lowering costs for older people and those with medical conditions while raising them for younger healthier people. It does not provide incentives to avoid freely chosen risky behaviors.” Young people often drop coverage rather than pay the high costs of subsidizing the premiums of their richer parents’ generation.
- “There is a disconnect between the consumer receiving health care and the entity paying the bill...Third party payment tends to shield consumers and provider from understanding the cost consequences of their behavior and of the health and medical choices they make.”
- Individual health insurance premiums are only partially tax deductible, and are thus penalized compared to fully-deductible employer premiums
- There are “enormous inefficiencies in the administration of health care” within the health care industry. Solving this problem deserves a full-fledged study.
- Vermont’s very low Medicaid provider reimbursement levels should be increased to merely low Federal Medicare reimbursement levels.

The report recommended an experimental “Incentive Plan for Medicaid”. Under it, 7000 enrollees in VHAP (expanded Medicaid) would get a state-funded smart card for health care expenses. The enrollee could use half of the balance at the end of the year to pay for job training, college credit, and similar programs. This is in effect a Health Savings Account, but without the essential high-deductible private insurance policy.

Legislative Action 2001-2004

Perhaps the most lasting result of the Hogan Commission report was the conversion of VHAP to a premium based insurance program, covering 48,000 enrollees. This was authorized by the FY2004 appropriations bill (Act 66) and carried out (with some difficulty) in 2003-04.

The major act of 2002 (Act 127) addressed the costs of prescription drugs used by the state’s Medicaid population. The method chosen was creation of a Medicaid Preferred Drug List, and authorization of state negotiation for “supplemental rebates” from pharmaceutical manufacturers in return for putting their products on the list. An effort to impose price controls on prescription drugs failed.

The 2003 legislature also passed a lengthy act (Act 53) reshuffling the government apparatus for controlling various parts of the health care system, notably health facility planning and reporting and hospital budget reviews. In response to revelations about huge cost overruns for the expansion of Fletcher Allen Health Care in Burlington, the act rewrote the Certificate of Need (CON) process controlling health care expenditures and facilities.

The new CON law established generally higher dollar-amount jurisdictional thresholds, except for home health agencies, where the threshold was reduced from \$300,000 in annual operating expenses to zero. This provision was urged by the state’s 12 regional home health care monopolies to erect an even higher barrier to the menace of for-profit competition. In another deft

special interest move, the state-funded community mental health advocates got their organizations exempted from the CON process altogether.

With the possible exception of the VHAP conversion to premium based (though still government run) insurance, the legislatures of 2001-2003 did nothing to reverse the command and control health care policies of the 1990s.

In 2004 the House made an effort to attack some of the underlying problems. In April it passed H. 759, a strange collection of conflicting provisions reflecting the close partisan balance of the House. The bill offered tax credits to small businesses that provided high deductible insurance coverage coupled with Health Savings Accounts (authorized by Congress beginning in 2004.) This measure, first proposed by Gov. Douglas, was frankly designed to discourage small businesses from dropping increasingly unaffordable coverage and sending their lower wage employees off to join deficit-plagued VHAP.

The bill also offered a “healthy choices insurance discount”, an important idea, but drafted in a way that would benefit only people who had made bad health choices (tobacco, alcohol, obesity) and then vowed to follow a program to do better. The bill prohibited insurance companies from extending the same discount to persons who had made healthy choices all their lives. The bill charged the Commissioner of BISHCA with policing patient compliance with each patient’s lifestyle improvement program.

The two most valuable (and non-controversial) provisions of the bill would have revived the common claims form mandated but never implemented by Act 160 of 1992, and created a state-led coalition to develop a statewide interactive health care database, patient education web sites, physician best practices references, and electronic data retrieval.

The friends of government health care succeeded in inserting a provision for a “health care cost containment council”, composed of at least four “panels” populated by the bureaucrats and interest group representatives. This council was authorized to carry out any imaginable command-and-control “cost containment activity” favored by the Commissioner of BISHCA.

In the course of passage the House deleted from the bill a provision sought by Gov. Douglas to create the equivalent of a high-risk pool. His proposed Small Market Access Reinvestment Trust (SMART) for the individual market, and possibly other markets as well, would have created a trust to pay the medical expenses of certain seriously ill individuals covered by conventional insurance plans. Without the high costs of caring for these individuals, the premiums for the other insureds could be reduced, according to Douglas, by “up to ten percent”.

The trust would be funded by a 1.4 percent assessment on the net operating revenue of hospitals, raising \$4 million, augmented with Federal grant money made available for state high risk pools. This in effect meant that the tax would be levied on the hospital’s customers – not only Medicaid, Medicare, insurance companies, and individuals, but also the hospital expenditures of self-insured “ERISA” employers who would otherwise escape a tax on premiums. The SMART proposal, however, foundered in the Ways and Means committee, which was unwilling to approve the tax provisions.

The House rejected 52-89 a Democratic proposal to create a board to propose a single payer plan for the state in 2005. Also rejected on a 61-80 vote was a Democratic proposal to allow small businesses to “buy in” to the Medicaid program. This would allow them to gain the advantage of the lower prices obtainable by Medicaid’s chronic underpayment to providers. It would also achieve another liberal goal by further shrinking the private insurance sector. This House passed the bill on a vote of 77-63.

The Democratic Senate would have supported the small business buy-in provision and possibly the single payer board. But with the prospects of an agreement with the House majority vanishingly small, the Senate took no action on the House passed bill, and let the issue die.

Vermont's Health Care Philosophy in 2004

Since 1991 Vermont's state government has aggressively moved ever further into the state's health care market. A review of the events of these fourteen years produces six major policy principles that underlie this progressive government intervention. They can be fairly summarized as follows:

1. Health care is "delivered". Patients are passive vessels into which competent professionals pour the elixir of "health care". Since "there is no such thing as an informed consumer of health care" (Howard Dean MD, 1992), health care should be delivered through managed care organizations, where treatment decisions are made by gatekeepers with incentives (or instructions) to restrain costs. Individual choices about health care and health insurance should be discouraged, because individuals make choices with only their own interest in mind, rather than the good of society as a whole.

2. The measure of social progress is the number of people whose health care expenses are covered by some form of "insurance", whether it is true actuarially-based insurance offered by an insurance company, or a promise to provide needed care offered by an HMO, Medicare, Medicaid or the Veterans Administration.

3. The ultimate goal of health policy should be "universal coverage", a medical-financial system comprehensively managed, through regulations, price controls, budget controls, reimbursements, taxes, and rationing, by a government "Authority". Only such a system can assure cost containment (that is, can ration care to match available revenues.)

4. Until such time as a "universal coverage" system can be put in place, the state should enroll more and more people, of higher and higher incomes, in taxpayer-paid Medicaid. Since the federal government pays 64 percent of Medicaid costs, every effort must be made to qualify proposed expansions with CMS, the federal administrative agency.

Since the state drastically underpays for Medicaid services, the remaining unpaid costs can be shifted to private health insurance premium payers. Many persons who then become uninsured because they can no longer afford the higher premiums can be covered by expanding access to the government program that produced the cost shift. This process steadily puts more and more Vermonters into taxpayer-financed health care, and constitutes desirable progress toward a single payer system.

5. Blue Cross, Vermont's only domestic health care insurer, has a special social mission. The commissioner of BISHCA must take all necessary steps to protect the financial stability and soundness of Blue Cross. This necessarily requires that the commissioner become deeply involved in its management decisions. An important part of the Blue Cross mission is to offer health care coverage to all customers at the same "community rated" price, regardless of the costs incurred by different kinds of customers. Thus the healthy and the sick, the old and the young, the rural and the urban, the male and the female, the lumberjack and the desk worker, must all pay the same premium for the same coverage.

6. Since by community rating Blue Cross can't compete with private carriers who charge customer groups on the basis of their expected claims — the practice long observed in life, auto, and property and casualty insurance — the law must prohibit all carriers from using actuarial or experience-based distinctions. This is the only way that Blue Cross can survive with its social mis-

sion intact. If competing insurers withdraw from the state rather than conform to this law, so much the better. Their political opposition to the expansion of government health care will thereby disappear, smoothing the path toward a single payer health care system.

What These Policies Have Produced

As a result of these policies, the political leadership of Vermont state government has brought about

- a massive exodus of commercial health insurers, and the collapse of a competitive health insurance market.
- an unfair burden on healthy young families, who are forced to subsidize the health care costs of sicker older people even though the older people are in their peak earning years and have long since paid off their education loans and home mortgages.
- an unfair burden on people who practice a healthy lifestyle, who are forced to subsidize others who smoke, drink to excess, use drugs, are obese, and underexercise.
- the steady conversion of privately insured Vermonters into uninsured Vermonters, and then into government-insured Vermonters.
- the recurring regulatory rescue of Blue Cross, which has become a virtual ward of the state.
- the costly overutilization of health care by government-certified patients who have come to regard it as “free”.
- serious and chronic state underpayment of hospitals and nursing homes for ever-increasing Medicaid services, which forces them to shift costs onto privately insured patients, thus driving up premiums and causing more Vermonters to drop their increasingly unaffordable coverage.
- serious and chronic state underpayment of doctors and dentists for ever-increasing Medicaid services, which forces them to limit the number of Medicaid patients they will treat, or to refuse to treat Medicaid patients at all.
- binding state control of hospital budgets, making hospital management and capital investment subject to political approval.
- an increasing cost burden both on businesses competing in interstate commerce, and on small businesses serving a local market, leading to reduced job growth and reduced employee insurance coverage.

All of this has been accomplished under constant pressure from political leaders for the expansion of government health care, with the goal of creating a state single payer health system that is managed by political appointees, provides virtually free health care for all Vermonters who are below Medicare age and do not work for large employers, does away with private health insurance, puts the state in control of all health care providers, requires them to ration care to meet politically-determined budgets, and sends the bills for everyone’s health care to the taxpayers.

These fourteen years have seen some success in expanding health care programs to serve more Vermonters, instead of meeting their needs through traditional charity care. But the result of this “success” has been the progressive destruction of a competitive health insurance market, an increasingly serious shifting of costs to health care providers and their private pay customers, and the rapid escalation of health insurance costs for employers and employees alike.

Fundamental Health Care Reform: Seventeen Steps

Two of the key features of true health care reform are equalizing the tax treatment of medical expenses and minimizing third-party payment for insurance claims. Both of these needed reforms, however, will require national action. There are nonetheless a number of steps that can be taken by the Vermont legislature to effect a market-based health care system.

A sound reform of health care in Vermont, including a badly needed revival of a competitive health insurance market, should be based on these principles and policies.

1. The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government. Over a lifetime – and especially up to Medicare eligibility age – individual choices are directly related to the great majority of health problems. The opinions of some doctors and program managers notwithstanding, patients are not mere passive receptacles for the delivery of health care. They are conscious human beings whose understanding, involvement and cooperation are essential to maintaining or restoring wellness. People who regularly make important decisions about family, career, and investments must be considered competent to recognize the essentials of healthy lifestyle choices and effective self-treatment for non-acute conditions.

2. Wellness can be significantly increased and demand for expensive health care can be significantly reduced if individuals are educated as to the personal health consequences of their choices, especially those relating to smoking, drinking, drug use, exercise, nutrition, and sexual activity. The explosion of health care information through periodicals and internet sources has led to a corresponding increase in patient awareness of health care considerations, self-medication, and lifestyle modification. Every public and private program, including especially high schools, should offer a strong health consumer education component, and reward individuals and families who make healthy choices.

3. Health insurance exists to protect individuals from unexpected occurrences. It was never intended to pay for expected and predictable wear and tear. First dollar or low deductible coverage leads directly to costly overutilization of health resources; the patient believes he or she is getting “free” care and thus consumes more of it, even though it yields little or no improvement of health outcomes. Such coverage should be strongly discouraged, even to the point of imposing a surtax on the premiums of first dollar policies.

4. Individuals and families should be encouraged to create tax-favored Health Savings Accounts (HSAs). HSAs are coupled with a relatively inexpensive high deductible major medical insurance policy. Employer and employee funds deposited in an HSA can be used to pay for such routine expenses as physical examinations, immunizations, vision care, prescription drugs, over the counter remedies, and all covered medical costs until the annual deductible is reached.

HSAs give families a financial incentive to use preventive care to maintain wellness. As balances in their HSAs increase, they can switch to higher deductible coverage and pay lower premiums without giving up major medical protection. In addition, many doctors will give up to a 25 percent discount for patients who pay for treatment at the time of service, a practice that an HSA makes easy. The federal deduction from income for HSA contributions carries through to state tax law, that uses the federal definition of adjusted gross income.

5. The legislature should repeal community rating. Insurance carriers ought to be allowed to distribute the cost of insurance fairly at least among recognized actuarial categories such as age, gender, geography, and occupations. This traditional method of pricing coverage justly assigns costs in proportion to expenses incurred. Community rating has the regrettable effect of

Ten Tools for Achieving Consumer Driven Health Care

American health care is moving rapidly toward consumer driven models built upon consumer-friendly information, choice, and two party relationships, backed by insurance coverage to protect against large and unpredictable medical events.

Every family has long used this consumer-driven model to select food, clothing, housing, cars, and vacations. It seeks to minimize third-party intervention, where an insurer, employer, provider, or the government decides what is medically necessary and what it will pay for. Its goal is to insofar as possible give patients control over information and resources, so they can ration their own purchases in light of their own values and priorities. Here are ten tools currently developing to bring consumer-driven health care into being.

1. **Health Savings Accounts.** Authorized for 2004, HSAs are individually owned (and thus portable) accounts funded with tax-deductible contributions from the individual, the employer, or both. The HSA is coupled with a high-deductible major medical insurance plan. The account owner uses the HSA to pay for health care expenses up to the deductible amount, where the insurance takes over. Unused funds stay in the accounts and build interest over time. (HSAs replace the MSAs authorized as a demonstration program in 1996).

2. **Flexible Spending Accounts.** FSA “cafeteria plans” can be established only by employers. Employees may assign part of their salaries into an account to pay for health care expenses. The accounts have a use-it-or-lose-it provision that requires unspent funds to be forfeited to the employer at the end of the year.

3. **Health Reimbursement Arrangements (HRAs).** First authorized in 2002, HRAs allow employers to fund employer-owned accounts from which employees can reimburse themselves for a wide range of health care expenses. HRAs may be used with any kind of insurance plan, and may be for any amount of money. Unlike FSAs, they may rollover and build-up over time.

4. **Indemnity Coverage.** Indemnity insurance, long common in property insurance, is a “two-party” contract in which an “insured” pays a premium for protection against future medical costs. The insured pays the health care provider, and is reimbursed by the insurer.

5. **Defined Contribution.** “Defined contribution” means that the employer provides a fixed

payment dedicated to employee health insurance benefits. Employees use that contribution to select from a variety of benefit plans, often supplemented with their own funds.

6. **Opt-Out Provisions.** These provisions in health care plans allow workers to use their employer’s defined contribution to supplement a spouse’s coverage, or for both earners to pool their funds to purchase coverage for the whole family.

7. **Direct Pay:** A growing number of physicians, either independently or as part of networks, are offering offer their care for cash (credit card) payment, at substantial discounts made possible by their dramatically reduced costs of dealing with third party payors (especially Medicare and Medicaid)

8. **Independent Medical Centers.** Some health care providers- often offshore - are starting to offer fixed prices for defined services. This is especially suitable for “focused factories”, facilities that specialize in one or a few treatments or procedures such as cosmetic surgery, heart bypass surgery, and hernia repair, achieving high volume, high quality and high efficiency.

9. **Expanding Insurance Markets.** Insurance markets have traditionally been rigidly separated by regulatory jurisdictions. By requiring expensive mandates (community rating, guaranteed issue, mental health parity, pregnancy coverage, etc.), state regulatory regimes deny consumers the opportunity to find the kind of insurance coverage that best meets their needs and resources. National “association plans” (not yet authorized by Congress) will allow association members to buy appropriate coverage not available in their own state.

10. **Information Technology.** Few of these changes could happen without the remarkable power of the CD and the Internet, which now allow consumers to identify their resources and match them up with preferred coverage or services.

“Health care is about people. The best way for people to express their needs, values and desires is through a market-based system that gives them the power to spend resources in keeping with those values.” – Greg Scandlen, Director of the Center for Consumer Directed Health Care at the Galen Institute in Alexandria, VA. This brief is based on a paper of the same title published by Greg Scandlen in 2003.

overcharging younger, healthier, but poorer families in order to subsidize older, sicker but wealthier (and thus more politically influential) families. Government mandates which have the effect of making the poor subsidize the rich are inherently unacceptable. Such mandates should be doubly unacceptable when their hidden purpose is to create a virtual monopoly for one struggling but politically influential health insurance company. The law should be changed to allow Blue Cross to use age and experience rating as well, while retaining its exemption from the premium tax to subsidize its existing high cost books of insurance.

6. Insurance carriers should also be allowed to offer healthy lifestyle discounts. Auto insurance carriers offer discounts for the absence of accidents and traffic violations. Property insurers offer discounts for fire protection. Most commercial health insurers offer discounts or “preferred” policies for non-smokers, etc. but such discounts are currently illegal in Vermont. The discounts should be made available to insureds on the basis of their lifestyle choices, and not limited to insureds who are struggling to overcome unhealthy choices as part of a government-qualified program.

7. Government mandates that force insurance customers to buy coverage they do not want and will never use should be rolled back. These include pregnancy benefits, excessive drug and alcohol abuse coverage, and mental health parity. Lower income families ought to be able to buy a minimum-benefit policy that does not require them to subsidize the health care costs of others who choose to practice unhealthy lifestyles, or pay the costs of normal pregnancy and childbirth. By thus reducing the cost of basic coverage, thousands of Vermonters who have been incorporated into Medicaid will once again be able to pay their own way.

8. The state should resolve to pay the true cost of services provided to Medicaid patients by hospitals, nursing homes, and medical professionals. There is always much room for debate over what such “true cost” is, but the present practice of often paying less than half of the going rate for Medicaid patients requires other patients to absorb a hidden tax on their own premiums to make up for what the government declined to tax openly.

Unless the state resolves to pay its fair share for the care of “government patients”, providers will simply decline to provide treatment. In the case of hospitals, it is not possible to turn away patients; thus they – and probably many doctors as well – will eventually be forced to serve state-designated patients at state-specified prices. Bargaining over these price schedules will in time make Vermont’s medical profession into the equivalent of a trade union, with predictable consequences for professionalism.

9. Medicaid for acute care patients (other than the elderly or institutionalized) ought to be converted into an HSA-style program, with the state providing sliding scale subsidies for individual accounts. The HSA offers real incentives for involving customers in maintaining their own wellness, because they will not only live healthier lives but will benefit financially. It would almost certainly be less expensive for the state to fund HSAs and buy corresponding catastrophic coverage for such Medicaid-eligible Vermonters, rather than continually expand managed care or first dollar fee for service coverage. Since the taxpayers would fund these HSAs, there would presumably have to be some limitations on the use of the account balances. Allowed uses might include the purchase of long term care insurance, continuing education and job training, or other investments in family earning power, wellness, and independence.

The conversion of VHAP to a premium based program in 2004, albeit with government remaining the “insurer”, is a step in the right direction.

10. The legislature ought to repeal the CON process, as many other states have done. The Federal government in 1974 pushed the government-issued “certificate of need” idea on the

states in what proved to be a futile effort to curb health care cost increases and duplication of services. By 1986 the Federal government had given up on the idea and repealed the mandate. Since then 20 states have repealed CONs, and 12 never instituted one.

Simply put, the CON process does little or nothing to restrain costs because politically powerful applicants eventually get what they want from the process (Fletcher Allen's \$326 million "Renaissance Project" comes to mind.) CONs' principal effect has been to protect monopolies against competition (and lower prices for consumers), even for home health care providers where capital investment is negligible. If a CON process is continued, it should be limited to very large capital projects and purchases of very expensive equipment that could lead to inefficient utilization.

11. The state should explore a program for the recapture of unpaid medical bills of persons who choose to spend their resources on things other than adequate health insurance. Such a program would be similar to an ordinary credit card account. The amount left unpaid by the patient would be debited to his account, and added back, over a period of years, to his reportable Vermont income. The amount added each year would be related to the patient's expected income level as indicated by previous returns. The proceeds after administrative costs of the additional income tax would be shared with the providers. Such a program could not realistically be expected to recover a large fraction of unpaid bills, but it would forcefully emphasize the individual's responsibility for paying for care received. In so doing it would have a positive influence on patient behavior.

12. The legislature should create a high-risk pool to cover the health care costs of the medically uninsurable – persons with known, costly health care problems who have been denied coverage by an insurer. Over 100,000 people in 28 states now participate in such pools, commonly called Health Insurance Plans (HIPs), which date back to 1978. A typical HIP requires insureds to pay 150 percent of the average premium for a comparable coverage, with premium subsidies available for lower-income insureds. It offers them a choice of competing insurance plans, including HSA plans and HMOs. Its costs are usually funded by assessing the premium receipts of all health insurers, or by general revenues, or both.

Typically the fraction of the population covered by a HIP is around one percent. An added advantage of the HIP pool is that it makes it unnecessary to mandate guaranteed issue on insurers. However, the HIP must be viewed explicitly as a means of covering only the medically uninsurable, not as a vehicle for expansion of government-financed health care.

The SMART plan proposed by Gov. Douglas (see above) would have fulfilled the functions of a high-risk pool, and the administration was in prepared to seek the federal grant available to support a startup. The 2004 House, however, declined to enact the proposal.

13. The legislature should examine and tighten tort liability standards governing medical malpractice to reduce the exposure of health professionals, hospitals, nursing homes, and HMOs to predatory tort suits. Provisions for arbitration of malpractice claims were included in Act 160 (1992) but were never put into practice because the universal access plan contemplated by that act was never adopted. The growing enthusiasm among trial lawyers for suing HMOs – and through them, the employer contracting with the HMO – makes this step one of high urgency.

Vermont has not yet suffered the fate of states like Pennsylvania, West Virginia and Illinois, where skyrocketing malpractice insurance premiums have caused a serious curtailment of access to providers. But the existence of an aggressive plaintiff's bar, coupled with the proliferation of high-dollar judgments in other states, suggests that the problem will grow here to similar magnitude.

14. The state should actively promote the purchase of long term care insurance. Act 160 of 1996 requires the state to “propose and implement methods that permit strategies to provide alternative financing of long term care services by shifting the balance of the financial responsibility for payment for long term care services from public to private sources by promoting public-private partnerships and personal responsibility for long term care.”

Gov. Douglas proposed in 2004 that seniors with adequate long-term care insurance should face less stringent asset spend-down requirements for access to Medicaid in their final years. The legislature declined to act on the proposal.

15. The state needs to move quickly to support the development of health care information and management technology. It is vital to start the process for integrating patient care, managing claims and billing, updating medical best practices for clinicians and specialists, and bringing user friendly health care information to consumers. Sec. 15 of H. 759 (2004) would have set this process in motion, but that section, perhaps the most valuable in the bill, disappeared with the bill itself.

16. Vermont’s ten independent community-based free clinics merit continued state support. These clinics offer primary and preventive health care, wellness counseling, pharmaceutical assistance, and referrals to free or discounted specialist services for needy, uninsured Vermonters. They make use of the volunteer services of health care professionals, including complementary treatment practitioners, students and community residents. Patients pay “what you can, when you can”.

Since 1999 the nine free clinics and the Burlington Health Center have received appropriations support, plus grants from foundations, federal programs, and community contributions. The grassroots free clinics serve a population that is often transient, between jobs, or otherwise hard to enroll in Medicaid, and do it as a genuine community service. A portion of the tobacco settlement fund should be set aside every year to assist the free clinics and encourage new clinics to organize in underserved parts of the state. AHS should refrain, however, from incorporating the free clinics into a bureaucratic system.

17. The legislature should, as essential housekeeping, revisit Act 160 of 1992 and systematically repeal all the provisions that failed, were ignored or abandoned, produced grievous consequences, or appear to commit the state to moving toward a government-controlled health care monopoly. Typical of the provisions meriting repeal is the statement of policy: “Comprehensive health planning through the application of a statewide health resource management plan linked to a unified health care budget for Vermont is essential.” Similar sentiments should be excised from Act 53 of 2003, another unwise endorsement of excessive government control and resource rationing.

The only alternative to a market-based “patient power” system proposed in this report is a totally government controlled “service delivery” system. Such a system, whether enacted in small stages or in one great convulsion, is the logical outcome of today’s health care policy.

Under such a system government becomes the single payer for all non-elective health services; private health insurance is illegal; patients receive only such care as the government agrees to pay for; hospitals and nursing homes operate on mandatory government-fixed budgets; all health care investments are strictly government-controlled; medical professionals, in effect if not in fact, work for the government; doctors, dentists, nurses, and technicians are unionized to protect their interests against a monopoly employer; and the bill for all covered health expenses is sent directly to the taxpayer. Why any reasonable person would favor such a system, variations in which are currently collapsing in Great Britain, Canada, and Russia, is hard to imagine.

The present Vermont system, though not single payer, is an increasingly defective hybrid characterized by the steady increase of government control over a once largely market-based system. Effecting a thoroughgoing market-oriented reform will require a major rethinking of public policy toward health care, and considerable political courage on the part of elected officials. Both are long overdue.

Useful References for Health Care Policy

Arnett, Grace-Marie, ed. *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: U. of Michigan Press, 1999)

Davis, Hamilton, "Health Care", in Michael Sherman ed., *Vermont State Government Since 1965* (Burlington: University of Vermont, 1999)

Ethan Allen Institute, *Reviving Health Insurance in Vermont* (2000)

_____, *Vermont's Health Care Policy* (2002)

_____, *A Health Care Agenda for Vermont* (2003)

_____, *Creating Choices for Home Health Consumers* (2004)

Gingrich, Newt, *Saving Lives and Saving Money* (Washington: Alexis deTocqueville Institute, 2003).

Goldsmith, Jeff, "How Will the Internet Change our Health System?", *Health Affairs*, January 2000.

Goodman, John C. and Gerald Musgrave, *Patient Power* (Washington: Cato Institute, 1992)

Goodman, John C., "Health Savings Accounts Will Revolutionize American Health Care", (NCPA Brief Analysis 464, January 15, 2004.)

_____, Health Savings Accounts (Testimony; U.S. Senate Special Committee on the Aging, May 19, 2004.)

Herzlinger, Regina, *Market Driven Health Care* (Reading MA: Perseus Books, 1999)

_____, *Consumer Driven Health Care* (San Francisco: Jossey-Bass, 2004)

Leichter, Howard, "Health Care Reform in Vermont: The Next Chapter", *Health Affairs*, Winter 1994.

A number of commentaries on health care policy in Vermont, covering the period 1994-2004, are available on the Ethan Allen Institute's web site, www.ethanallen.org, along with all of the referenced Institute reports.

A final note: This report does not go into detail on the very important subject of transforming health care systems, now the subject of serious nationwide attention.

The Center for Health Transformation (www.healthtransformation.net) has become a leader in state reform efforts, along with the Galen Institute (www.galen.org), the National Center for Policy Analysis (www.ncpa.org), and the Progressive Policy Institute (www.ndol.org).

The Patient Safety Institute (www.ptsafety.org) has focused on improving actual patient care and empowering patients.

The American Legislative Exchange Council (www.alec.org) has done valuable work in civil justice reforms.

The pages of *Health Affairs*, *Health Care News*, and regular reports in the *Wall Street Journal* are also invaluable references.