

Evaluating Health Care Reform Proposals: A Primer



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in conjunction with



Executive Summary

No one knows how much the people of the United States should spend on health care. When medical innovation improves treatments that relieve suffering and prolong life, people naturally spend more on health care. People also spend more on health care as they become wealthier. When American household incomes rise, people spend more on health care along with everything else. When government promises to provide free health care, people want more of it.

Strong evidence shows that private health care systems in which people spend their own money on the health care they want, using the financing arrangements that make sense for them, provide better care at lower cost. When people buy their own medical care they reward providers for rapid diagnosis, effective treatment, and convenient care at the lowest possible cost. Individual control of health spending directs money to medical care suppliers who do the best job of meeting those goals. Innovations that improve patient care or lower patient costs are rapidly adopted, often changing the very structure of health care delivery.

When governments control health spending, patient needs take a back seat to the needs of politically powerful interest groups. Overall costs generally increase and the quality of care declines. Innovation slows dramatically as groups receiving government payments fight changes that might reduce their revenues. When government spending to provide “free care” replaces private spending, people demand more care and official government expenditures increase beyond initial predictions. Governments at all levels respond to higher than expected spending by doing whatever they can to shift health care costs from official budgets to patients and providers.

Government run health systems in the United States and the rest of the industrialized world shift large health care costs onto patients and providers by limiting access through waiting lists, paying providers below market rates, underfunding maintenance, and simply refusing to provide care. Overall, US Medicare pays hospitals less than their costs. If private insurance were replaced by Medicare, hospital quality would decline as payments levels would be insufficient to support existing staff or replace existing buildings and equipment.

Analysts who say the US spends too much on health care compare US spending to spending in countries with large government run health care systems. To make those comparisons accurate, they generally assume that government reimbursements are prices. But reimbursements reflect politically guided administrative decisions about budgets, not the market value of the resources used to provide health care. Spending too little on health care by setting artificially low budgets and reimbursements creates care shortages and increases morbidity. Accurate comparisons of cross-border spending are impossible without accounting for those costs. What counts as health care spending also matters. For many years, official Japanese estimates of health care expenditure did not include spending on long-term care services or payments for services not covered by public health insurance. Including those and other expenses increased Japanese health spending to an estimated 127.4 percent of its previous total.

Does England really have lower health care costs than the US? In 2013, the English National Health Service estimated that its average expenditure for surgery to repair an uncomplicated hernia was

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\$2,500. During the same period, the cash price of a simple hernia repair in the US was around \$4,000. Hernias do not repair themselves, and they often increase in size over time. Untreated cases sometimes need emergency surgery.

In the US, hernia repair is routine, and patients schedule it at their convenience. In England, simple hernia repair is considered a low value procedure. Access to surgery is denied until the pain from a hernia is serious enough to impede day-to-day activities like going to work. Once surgery is approved, the average wait is five months.

Some people in England think that free hernia repair from the National Health System is too expensive. They pay cash for prompt, American style, all-inclusive hernia repair at private English surgical centers. Those centers advertise prices that are roughly the same as the cash price in the US. Whether an individual thinks US-style hernia repair is “too expensive” will depend how much he values an extra dollar, an extra pain free day of life, or the reduction of risk provided by immediate repair.

For these and other reasons, three basic principles should be used when evaluating proposed health policy reforms:

1. **People spend less when their medical spending is financed with their own money, even if that money is augmented by a government payment or an employer contribution to a health savings account** — individuals spending their own money are more likely to be alert to fraud and less likely to tolerate being billed for services they did not receive or do not want. Government entities have limited administrative capacity and a demonstrated inability to competently

manage complicated subsidy programs. The best reforms will limit subsidies to clear cases of illness or disability and be awarded to the individual who needs the medical care.

2. **Reforms shifting costs from one group to another using price controls, taxation, regulation, or mandates should be avoided** — they distort prices, making it impossible to know how much any health service costs. As far as possible, government health care subsidies should be explicitly budgeted, and the funds to pay for them should come from general tax revenues rather than from hidden taxes on hospitals, insurers, physicians, pharmaceutical companies, hospital patients, or other businesses or individuals.
3. **Reform proposals that substitute government spending for private spending increase health expenditures, increase health care costs, decrease innovation, and harm the sickest patients** — politically controlled health systems typically spend less on screening and treatments for seriously ill people than individuals would like. Interest group politics makes them difficult to change, hostile to innovation, and prone to wasting money on activities that individuals would not willingly pay for. Programs financed by tax revenues also create deadweight economic losses by reducing the production of the goods that are taxed and increasing consumption of the goods that are subsidized.

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Introduction

People have been reforming US health care ever since the Carnegie Commission funded the 1910 Flexner Report. In Colorado, the modern push to centralize control of health care in state government dates to 1992 when the Romer administration began taking grant money from the Robert Wood Johnson Foundation. The Foundation wanted to replace private health care decisions with government health care decisions. The initial grant was made in order to “enable Colorado to reach consensus around a single model of universal health care access.”¹

More government is not the answer to American health care cost problems. In fact, extensive evidence from the US and other industrialized countries shows that increasing government involvement increases health care costs. The health care reforms that have demonstrably reduced health care costs are those that have reduced government involvement, liberating patients and providers to spend their money as they see fit, allowing them to discover new ways to deliver medical care that people want and are willing to pay. Those reforms empower people. They reduce government control over people’s actions, freeing health care providers from unnecessary restraints on how they care for patients. Unfortunately, reforms reducing regulation and liberating individuals from central control remain intensely unpopular with those who are predisposed in favor of government run health care.

The policies flowing from the Colorado state government’s capture by wealthy health foundations favored reforms that increased government control over private health care arrangements. Most new health care legislation substituted government health care payments for individual health care payments

or extended state control over the private provision of health care. When government payments replace private payments, people consume more health care and interest groups try to expand payments.² Since few people in government have an incentive to restrict government expenditures, government health care expenditures grow much faster than initial predictions. In Colorado, government has sought to fund its new expenses by imposing more taxes on those who pay for their own health care and reducing state spending on other programs. It attempts to control health care expenditures by limiting health care access and discouraging physicians and hospitals from providing care it considers too expensive.

Expanding excess spending on government health programs cramps government spending on other services. Governments at all levels try to protect spending on non-health programs by regulating health care spending in ways explicitly designed to reduce government expenditures. Sometimes these are presented to the public as efforts to limit excessive health care costs. Sometimes they are presented as wise use. Reductions in health care access and quality that patients cannot see are less likely to produce political repercussions.

One way to limit access to care is to allow patients access to only a small panel of physicians and hospitals, a narrow network, with long waits to see specialists, and lengthy protocols that must be followed before people can access treatments. Another way to reduce access is to set the prices paid for medical tests or treatments below the point at which suppliers can afford to supply them. Suppliers will simply stop making those tests and treatments readily available, and

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the officials who set the prices can escape blame by criticizing greedy physicians, corporations, or hospitals to divert attention from their expenditure reducing regulatory schemes.

The regulatory thicket has grown so large that it now creates significant resource misallocation, requiring, for example, too much spending on administration and too little on patient care. When government intervention creates new problems, rather than proposing a rollback of the regulations that created the problems in the first place, advocates often propose more government programs, and more spending, to fix the problems that government created. At some point government becomes unable to provide the health care it promises. It focuses its attention on finding politically acceptable ways to lower expenditure by skimping on medical care and avoiding accountability.

Very few of the health reforms proposed for Colorado and the rest of the US are new. Most have already been tried in

the US or abroad. People interested in understanding how new reform proposals will affect them would be well advised to consider the results they produced in other contexts. As this paper will explain, claims that the US spends too much on health care almost always ignore the high costs of government run health systems because accurate system expenditures are seldom available. Generally available data ignore the cost generated by extensive patient waiting for care, do not include the costs generated by lost production due to tax financing, and are uninformative about how overhead is funded. Reform advocates often ignore the general deficiencies in the international data they use to make comparative claims about US system costs, and ignore the malign effects of government control on innovation. They also ignore individual outcomes by emphasizing “population health” over individual well-being.

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Part I—An Introduction to Health Care Policy Analysis: Does the Colorado Reinsurance Program Lower Health Care Costs, Raise Health Care Costs, or Just Shift Costs Around?

Like many others, Colorado Governor Jared Polis and elected officials in the state legislature think US health care costs are too high. In 2019 they said they were lowering health care costs by creating a state reinsurance pool to subsidize companies offering individual health coverage in 2020 and 2021. Officials claimed that by substituting state funds for private funds in the payment of “high cost claims,” individual insurance premiums would fall by 15 to 30 percent.

“Anytime you lower health-insurance costs,” Governor Polis said, “you’re also increasing access by making it more affordable.”³ Officials say that a state run reinsurance pool will reduce costs by reducing premiums for individual insurance. They do not mention that the high individual premiums the reinsurance pool plan is supposed to fix were caused by the Affordable Care Act of 2010. It more than doubled Colorado individual health insurance premiums by giving

government control over individual health insurance policy content and pricing. Before the Affordable Care Act took effect, Colorado had some of the most reasonable individual health insurance premiums in the United States and even people who had pre-existing conditions paid less than they do now.

In the US, the private health and medical reinsurance market is well developed. IBISWorld estimated its 2019 sales at about \$19 billion a year. Using government money to help companies that provide health coverage pay their high cost claims substitutes government money for private payments. Reinsurance premiums depend on risk, past losses, and the capital available to fund new policies. In health care, the price an insurer or a self-insured company pays for reinsurance depends on its past claims, and the health of its current employees or policy holders. For example, in the 1960s, the life-expectancy of a baby born with hemophilia was about 20 years. Today, that baby can expect to live a normal lifespan with proper treatment⁴ and, if he is one of the estimated 1,500 Americans suffering from hemophilia with inhibitors, his health care costs may exceed \$1 million a year, every year.

The Colorado reinsurance program is structured to look like real reinsurance coverage—for claims above X amount, the state will pay 20 percent of the cost up to a cap of Y—but it is not reinsurance because there is no risk pricing. The amounts the state will pay depend upon available funds and are designed to decrease individual premiums in the politically sensitive mountain towns.

The Colorado plan subsidizes insurance company costs by replacing private claims payments with public payments. Rather than reducing health care costs, it shifts them around. While people who purchase

individual health coverage may enjoy lower premiums, the new government funding must come from somewhere. In this case, it will be funded by Colorado taxpayers, taxes on Colorado hospitals, and taxes on health insurers. As always, taxes on health insurers and hospitals will ultimately be paid by patients and those who buy health insurance. To make the new payments required by government, hospitals and insurers must either raise their prices or reduce their costs by providing fewer services for the same price.

To say that giving insurers more money to cover their claims expenses will necessarily lower individual premiums is a lot like saying that giving more money to public universities will lower tuition. Universities can lower tuition, or they can hire more administrators, build more buildings, boost professor salaries, and reduce staff workload by cutting professorial teaching loads. As figure 1 makes clear, reducing tuition is not the path that public universities have generally chosen.

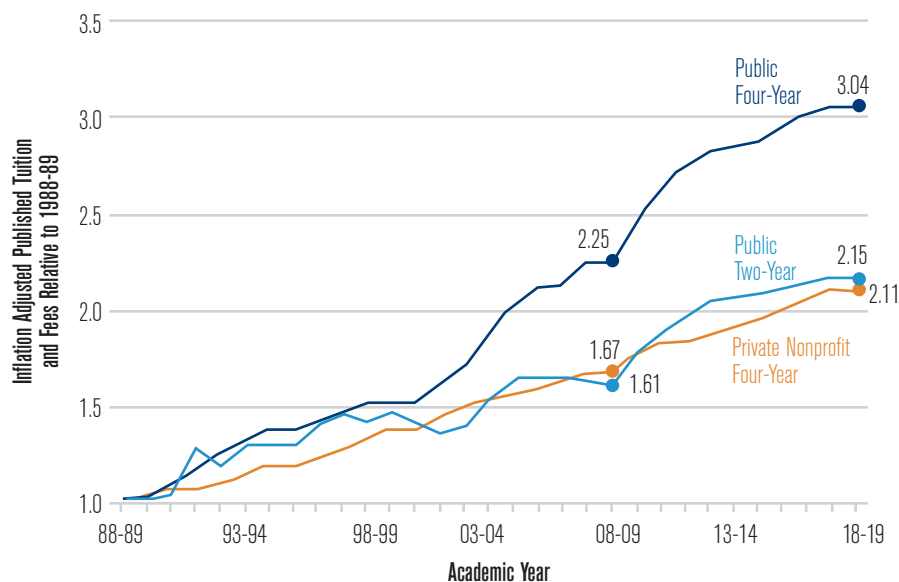
What are the basic numbers underlying the reform proposal?

Keeping basic numbers in mind often helps when analyzing the likely costs and benefits of proposed health care reforms. For Colorado's reinsurance pool, one of the basic questions is how many high cost claims there are, and how are they distributed?

Figure 2 shows the health care insurance claims distribution developed for a 2011 Milliman report on benefit designs for high cost medical conditions.⁵ Amounts are in 2010 prices for 28 million people with commercial insurance in 2008. The report defined high cost claims as individuals with an amount owed in claims exceeding \$100,000 in a calendar year. In general, the high cost category included neonates with extreme problems,

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Figure 1: Inflation-Adjusted Published Tuition and Fees



Source: College Board, Annual Survey of Colleges; NCES, IPEDS Fall Enrollment Data. <https://research.collegeboard.org/trends/college-pricing/figures-tables/published-tuition-and-fees-relative-1988-89-sector>

Given that so few people have high cost claims, evidence that high cost claims have caused the Colorado premium increases is slim at best.

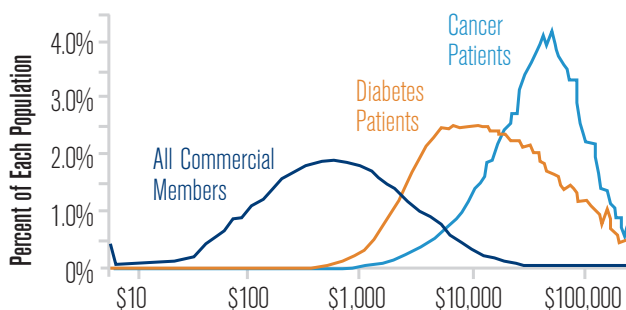
people with HIV, hemophilia, and end-stage renal disease, transplant patients, those with severe strokes, and people needing cardiovascular or cancer surgery and chemotherapy.

Claims over \$100,000 were rare. Only 0.2 percent of people in this claims sample fell into that category. Slightly more than half of all people with claims had total annual claims costs under \$2,000 a year. Averaging all claims over all covered lives produced an average annual claims cost of \$4,000. According to the Milliman

Medical Cost Index, by 2018 the average expected claims cost for an insured individual covered by a Preferred Provider Organization in an employer group plan was \$6,116 in 2018.⁶

Given that so few people have high cost claims, evidence that high cost claims have caused the Colorado premium increases is slim at best. Most people still spend relatively little on health care in any given year, and prior to the Affordable Care Act, risk-based health insurers could make a profit by charging people relatively small

Figure 2: Health Expenditure Distributions, Commercially Insured 2008



Source: Kate Fitch and Bruce Pyenson, April 22, 2011. Benefit Designs for High Cost Medical Conditions. Milliman Research Report, Milliman, New York, New York, p. 5. <https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/research/health-rr/benefitdesignshighcostpdf.aspx>

monthly premiums and promising to pay for large claims. But the Affordable Care Act limited the types of policies that could be sold, dictated how insurers could price them, and created new ways for individuals to game health insurance. People spending their own money to buy coverage prior to the ACA typically chose policies that covered relatively rare and costly events. They paid out-of-pocket for routine costs like mammograms, occasional physician visits, and routine prescriptions. ACA policies forced people to buy policies that prepaid for routine events and required them to pay for people with extremely expensive diseases who may not have started paying premiums until they developed their disease.

What baseline will be used to measure policy success or failure?

While the cost of claims for self-insured employer plans increased by slightly more than half from 2008 to 2018, premiums in Colorado's individual health coverage market more than doubled from 2011 to 2019. Table 1 shows how much approximate premiums changed for a 30-year-old man after Obamacare standardized individual coverage, imposed lockstep pricing, and ended the practice of individualizing policies in 2014.

Compared to 2011 premiums adjusted for the annual increases in large employer health plan costs, Obamacare increased

Compared to 2011 premiums adjusted for the annual increases in large employer health plan costs, Obamacare increased the premium for a healthy 30-year-old living on the Front Range by an estimated 88 percent.

Table 1: Obamacare and Insurer Subsidy Effect on Comparative Approximate Monthly Colorado Health Coverage Premiums for 30-year-old man

	Before Obamacare 2011	After Obamacare 2019*	With Reinsurance Subsidies 2019, Estimated
Pre-existing condition, \$5000 deductible, Front Range—other locations a maximum of 9% higher.	\$172	\$286*	
Average, \$5,000 deductible, Front Range	\$116	\$193*	
Obamacare Bronze plan, Front Range		\$363	\$301
Obamacare Bronze plan, Mesa County		\$580	\$480

*extrapolated, using 2012 through 2019 PwC Health Research Institute Medical Cost Trend estimates for large US employer group plans. <https://www.pwc.com/us/medicalcosttrends>. Note that the plans are not strictly comparable because people purchased different sorts of coverage before Obamacare dictated plan content and pricing. Source for premium comparisons with and without reinsurance subsidy plan: Busch *et al.* January 4, 2018. Two-page Summary of Final Reinsurance Report, Letter to Michael Muldoon, Chief Actuary, Colorado Division of Insurance.

Table 2: Estimated 2020 Annual Premium Increases Resulting from the Obamacare Federal Health Insurer Provider Fee

Type of Insurance	FHIP Premium Increase
Individual	\$170
Small Group Family	\$422
Federal Employees Single	\$149
Federal Employees Family	\$437
Medicare Advantage	\$224
Medicaid	\$131

Source: Carlson et al. August 28, 2018. Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later, Oliver Wyman, Milwaukee, Wisconsin. <https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf>

Like virtually all government health care reform proposals, the reinsurance program raises health care costs as well as shifting them around. It is to be funded by an additional \$55 million from the state general fund over the next two fiscal years, new Colorado hospital fees of up to \$40 million a year, and state and federal taxes on health insurers.

the premium for a healthy 30-year-old living on the Front Range by an estimated 88 percent. It increased premiums for an uninsurable 30-year-old living on the Front Range by 27 percent.

Colorado’s average Obamacare Silver plan benchmark premiums doubled from 2014-2018. If the reinsurance subsidy program works as advertised, it will reduce the Obamacare increase for a healthy 30-year-old from an extrapolated 88 percent premium increase to an extrapolated 56 percent premium increase. That means it reduces premiums relative to 2019, but it does not reduce premiums relative to the premiums that would have been in effect had the Affordable Care Act never been passed.

Is the proposed policy lowering costs, raising costs, or just shifting costs to others?

In 2017, actuaries from Milliman estimated how much Colorado would have to spend on reinsurance program insurer subsidies in order to reduce premium costs by various amounts in the post-Obamacare individual insurance market.⁷ On average, creating a premium reduction of 4.2 percent for the premiums of the roughly 250,000 people in the individual insurance market would cost the state \$34 million and the federal government \$36 million. To reduce premiums by 21 percent would

cost the state \$178 million and the federal government \$166 million. Thanks to the Affordable Care Act (ACA), the average person with individual coverage already receives federal subsidies of \$6,300.⁸ The Colorado state government plans to spend an additional \$334 million, an additional subsidy of more than \$1,300 per person, to “fix” an alleged market problem that was caused by previous government intervention.

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Under the reinsurance program, people with fully-insured non-group coverage pay higher premiums to fund the reinsurance program designed to lower premiums for those purchasing individual coverage. Some of the reinsurance subsidy money

Table 3: Estimated Colorado Health Insurance Enrollment for 2018	
Individual Coverage from Obamacare Exchange	151,000
Eligible for Obamacare subsidies	99,000
Not Eligible for Obamacare subsidies	52,000
Individual Coverage Off the Exchange	96,000
Total Individual Coverage	247,000
Fully-Insured Group Coverage	963,000
Total Fully-Insured Coverage	1,205,000
Self-Funded Group Coverage	1,866,000
Total Privately Insured	3,070,000
Source: Milliman. November 22, 2017. Actuarial Report to the Colorado High-Risk Health Care Coverage Task Force, Final Report.	

derives from the Obamacare Federal Health Insurers Provider Fee. The Fee was imposed on health insurers by the Affordable Care Act. It is not tax deductible. Actuarial firm Oliver Wyman estimates that in order to pay an additional \$1.00 in federal insurer fees at a corporate tax rate of 21 percent, an insurer must raise premiums by \$1.27. Estimates of how much this tax increases premiums for people who have other kinds of health coverage in Colorado are given in Table 2.

If the reinsurance program works as advertised, the individual market premiums will be \$1,500 less than they would otherwise be. As Table 3 shows, the almost 1.2 million people covered by fully-insured employer coverage will pay \$200-\$400 more each year to lower premiums for the 247,000 people who purchase individual coverage.

The reinsurance program cost estimates do not include the premium increases that will be caused by the new taxes on hospitals. Colorado's state officials apparently believe that hospitals get money from other sources than their customers as the reinsurer subsidy statute specifically states that hospitals are prohibited from passing the fee increase onto consumers in any manner.

While Colorado legislators may believe that tooth fairies leave money under hospital pillows, in the real world hospitals must find a way to extract the extra \$40 million from those who pay for their services. In general, they can do it in one of three ways. They can charge patients more, they can reduce their costs by reducing their services, or they can hope for big cash gifts.⁹

As charity tends to be limited, the most likely outcome is that patients pay more and patients get less. Paying the same amount and getting fewer services is no

less a cost increase than paying more to get the same services. As is almost always the case when government officials try to shift costs around to disguise the effect of problems that government created, the problem with the insurer subsidy is that the more carefully the taxes and subsidies are hidden, the more difficult it is to determine what the real costs are. Opportunities for special interest group self-dealing mushroom in the dark spaces of complex subsidy schemes, and the cost increases caused by the new taxes and fees needed to pay for them can always be blamed on hospitals or insurers rather than on legislators operating under the cloak of reform.

Though Colorado officials tout the reinsurance subsidy program's 20 to 30 percent reduction of premiums, a 30-year-old man with a pre-existing condition and a Bronze Obamacare plan would be paying an estimated \$2,000 less in annual premiums had the Affordable Care Act not taken a wrecking ball to the market for individual health insurance. Using insurance subsidies to reduce his premium does save him around \$1,300, but that is not enough to erase the cost increases caused by the naïve Affordable Care Act insurance regulations. To make matters worse, insurers already receive roughly \$500 million in subsidies to pay for the policies of 99,000 Coloradans who are already eligible for ACA premium subsidies.¹⁰

Have programs based on similar policy ideas worked?

There are already so many different subsidy programs in existence that new subsidy schemes are hard to find. This means that looking at how existing subsidy programs work in practice often provides a useful guide to how a proposed reform using a similar subsidy method will actually operate.

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Officials promised that Medicaid expansion would reduce the number of uninsured, the value of unpaid hospital bills, and would result in lower private insurance premiums.

The reinsurance program directly subsidizes insurers, trusting that they will pass the additional cash to their customers by lowering premiums. In 2007, Colorado state government attempted to reduce hospital charges by directly subsidizing hospitals, trusting that hospitals would pass the additional cash to their patients by lowering their charges. In 2007, Colorado health policy makers claimed that coverage premiums were high because the uninsured did not pay their hospital bills. The cost of the unpaid bills, they said, was shifted to people with coverage. This was called cost-shifting, and people who paid for their own health care were promised that their premiums would fall if there were fewer uninsured patients. Expanding Medicaid by making more people eligible was supposed to reduce the number of uninsured, and the number of people who did not pay their hospital bills, by shifting the responsibility for payment to taxpayers.

Though economic research provided little support for cost-shifting, the story made superficial sense. Colorado officials and allied interest groups repeated it over and over as they campaigned for Medicaid expansion. Casting cost-shifting as a major driver of increased costs for private coverage helped build public support for provider taxes on inpatient and outpatient hospital services. Officials promised that Medicaid expansion would reduce the number of uninsured, the value of unpaid hospital bills, and would result in lower private insurance premiums.

In order to fund Medicaid expansion, in 2009 the newly Democratic Colorado legislature passed House Bill 1293 imposing new taxes on hospital and outpatient services in 2009. The taxes, which were called fees in order to evade Colorado's constitutional requirement for a popular vote to approve any new taxes, flowed into an enterprise fund outside of the state's Taxpayer's Bill of Rights

(TABOR) spending limitations. The fund also collected the additional federal Medicaid matching funds generated when the federal government paid half of the newly imposed taxes on hospital bills.

The fund was controlled by a politically appointed Board of Directors. In addition to Medicaid expansion, it provided money for grants to hospitals treating significant numbers of Medicaid patients. Like the reinsurance pool's grants to insurers, the grants to hospitals were supposed to reduce hospital charges. The bill's preamble even declared that the state needed hospital taxes paid by the sick to further a "common commitment to comprehensive health care reform," "reduce the underpayment to Colorado hospitals participating in publicly funded health insurance programs," and reduce "the need of health care providers to shift the cost of providing uncompensated care to other payers."

Ten years later, there is little evidence that subsidizing hospitals with public cash and Medicaid expansion have done anything to reduce hospital charges. A recent report by the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), the group controlling the revenue stream from the provider tax, admits that the state has failed to reduce the cost shift. It even notes that the cost shift may never have existed.¹¹

As the hospital subsidy scheme failed to lower hospital charges, it would make sense for the state to end the program and reduce health care costs by eliminating its taxes on hospital services. Instead, CHASE is acting like the interest group it is. Its officials now claim it really, truly, can reduce hospital costs provided the state legislature gives it more regulatory power to make hospitals do what it wants. Based on past results, there is no reason to believe that a group of 13 political appointees will

do a better job of managing and financing acute care for very sick people than the hospital owners and managers who have spent their careers doing it. There is good reason to believe that CHASE is little more than just another interest group feathering its nest at public expense.

Are there less expensive ways to subsidize the target group?

Once government determines it will subsidize a group of people, attention turns to how to do it. There is no guarantee that any particular subsidy program is either effective or efficient because almost all subsidy programs have the potential to benefit a variety of interest groups other than the people targeted for the subsidy. Those benefits will vary depending on the subsidy program that is adopted, and every single interest group always does its level best to encourage the political system to choose the subsidy system that most benefits it. Subsidy program formats range from direct grants of cash to individuals to direct grants of cash to states with the understanding that states should provide for individuals. They also include a host of regulatory changes designed to allow subsidy targets to access the desired product or service on advantageous terms.

Experiments with food subsidies have ranged from providing actual food to nationalizing agriculture. The US Supplemental Nutrition Assistance Program (SNAP), provides a means tested cash equivalent that allows people receiving the subsidy to buy food in the same stores, and at the same prices, as people paying for their own food. The program cost is clear, generally the cash budget used to subsidize individuals, and it is funded from general tax revenues rather than from taxes on food that make food more expensive for people not on the program. Finally, the program does

not seek to control food prices or food suppliers. Because it does not meddle in pricing or supply decisions, food producers continue to compete to find the most efficient means of production and distribution and their customers' preferred combination of quality, convenience, and cost.

Some governments have sought to subsidize food using price controls. They determine how much food should cost, dictate food prices, and control how food is produced and distributed. In health care, this subsidy method is equivalent to having government take over the health care system with some sort of Medicare for All plan. Over time, the results of government food takeovers have been uniformly disastrous, leading to significant drops in production, food shortages, and widespread hunger.

Government managers and those they employ commonly lack the technical know-how and management skills needed to run agricultural operations, food production, and food distribution. Even if they had the technical ability, the lack of a price system to coordinate the far flung activities needed to get food from farm to table means that the production process the government chooses will almost certainly be less efficient than the processes chosen by private producers. Less efficient production processes waste significant resources. More damage occurs when government price controls set prices below costs. Food producers begin operating at a loss. Eventually they shut down. The extensive regulation that always accompanies government control, and the interest group opposition to any change in the subsidy program no matter how poorly it operates, makes innovation difficult or impossible.

It makes little sense to embrace costly "new" health care reforms if they use subsidy methods shown to be more

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expensive and less efficient than other methods that do much the same thing. In general, more efficient subsidy programs clearly identify who will be eligible for subsidies and use specific eligibility markers that are difficult to forge. They deliver subsidies directly to the people selected for subsidy rather than to bureaucrats many levels above the intended recipients. If delivery to individuals is impossible, they deliver subsidies to people who are as close to the point of service as possible. In order to preserve the production signals generated by the price system, subsidy funding should come from general tax revenues, not from taxes on small groups of users or producers, or price controls. Good subsidy programs also minimize interest group distortions with transparent budgets that have easy to calculate payments and funding sources.

with the Affordable Care Act policies, CoverColorado premiums varied by geographic location, but the variation was much smaller. Affordable Care Act premiums in some areas are as much as 40 percent higher than those in Denver.¹² Regional variations in CoverColorado's premiums were no more than 7 percent higher than Denver's.

Unlike the Affordable Care Act, which directs subsidies to perfectly healthy people based on their estimated annual income, CoverColorado focused health care subsidies on people who wanted to purchase health coverage but were unable to get it due to poor health. Chronically ill people with more than 30 well defined medical conditions were automatically eligible. Individuals who had applied for a commercial policy and were turned down due to their poor health, who were accepted for coverage but charged a premium price that was higher than the one charged by CoverColorado, or who involuntarily lost their coverage for any reason other than committing fraud or not paying the premiums were also automatically eligible.

If someone had continuous insurance coverage but lost it due to circumstances beyond their control, losing their job and their employer coverage or losing coverage because an insurer left the state, he could purchase full coverage from CoverColorado at any time without waiting for an arbitrarily defined open season. If someone did not have continuous coverage, CoverColorado had the option to issue a policy that covered future illnesses but not pre-existing conditions for up to a year. People with incomes under \$40,000 a year enjoyed higher subsidies in the form of lower premiums.

While ACA policies are largely HMOs, some of which have infamously narrow

A closer look at the pre-ACA cost of insuring Coloradans gives an idea of how much more costly the ACA solution really is.

Compared to past subsidy programs with the same target, the authors of the Affordable Care Act (ACA) chose to provide major medical coverage for people with pre-existing conditions using a less efficient, more costly, subsidy method. Though ACA coverage reforms in the individual insurance market are always presented to the public as a major achievement of the ACA, federal law had required every state to provide coverage for people with pre-existing conditions for over a decade before the ACA was passed.

A closer look at the pre-ACA cost of insuring Coloradans gives an idea of how much more costly the ACA solution really is. Before the ACA, Colorado offered subsidized major medical coverage through CoverColorado. Begun in 1991, CoverColorado offered PPO plans with deductibles ranging from \$1,000 to \$10,000. Some were even eligible for health saving accounts so that people with serious illnesses could use pre-tax dollars to pay for their higher than average health care costs. As is the case

networks, the 2013 CoverColorado policy book described its plans as PPOs with a broad network that included “any physician, Hospital or other medical care Provider in the State of Colorado for Covered Services” at the “CoverColorado-Specific Fee Schedule.” The plan contracted with the Rocky Mountain Health Plan multi-state network, so some out-of-state providers were also included. In addition to CoverColorado, the state of Colorado also funded the Colorado Indigent Care program. It provided subsidized hospital care at selected hospitals for individuals who were uninsured and suddenly needed hospital care. Individual payments were assessed on a sliding scale that varied with an individual’s income.

The CoverColorado subsidy program did not control prices or tell suppliers what to do. It simply set its premiums at 147 percent of the average individual health insurance premium paid by healthy people who bought the 5 best-selling individual policies in Colorado. Simply copying the pricing and plan decisions made in the competitive market for private health coverage kept CoverColorado’s administrative costs low. At the time it closed, CoverColorado had 8.5 employees. Premiums paid for about half of total medical costs, and subsidies for 13,000 people with pre-existing conditions cost about \$57 million. Twenty million dollars came from state tax revenues in the form of tax credits to health insurance carriers and the sale of unclaimed property. The rest was collected by “assessing” people who purchased health insurance in Colorado. In 2011, the “assessment” cost individual policy holders about \$40 a year.

The ACA subsidy program for the same group of people is so inefficient that its high prices are driving people out of the individual health insurance market even though the federal government spent \$636

million subsidizing individual insurance policies in Colorado alone in 2018.¹³ Even if both the 2013 CoverColorado premium and the subsidy doubled had doubled since 2013, increasing CoverColorado subsidy costs to \$114 million, subsidizing uninsurable people using the narrowly targeted CoverColorado method would still cost less than the ACA subsidy method.

Because ACA individual health coverage premiums are subsidized in complex ways, the price of coverage no longer represents the cost of coverage. Instead, it represents the cost of paying claims minus subsidy costs that artificially raise costs for hospitals, insurers, medical device suppliers, drug companies, and people with incomes that put them above the subsidy limits. Thanks to provider fee taxes that collect money from private payers buying hospital services and the redistribute the money to different Colorado hospitals, hospital pricing no longer reflects the real cost of providing hospital services. Multiply these two examples by the other subsidy programs federal, state, and local governments impose on health care providers and the result is that outside of the cash markets, US health care prices do not reflect the actual cost of producing US health care.

Because ACA individual health coverage premiums are subsidized in complex ways, the price of coverage no longer represents the cost of coverage.

Part II—Watch Out for the Hidden Subsidies: Expenditures are Not the Same As Costs, Especially in International Comparisons.

Health subsidy webs in other countries are older, and even more complex, than some of those in the United States. As in the US, the prices charged for health care do not reflect the actual cost of producing health care and health care expenditures are not the same as health care costs. When comparing health care costs in those countries with health care costs in the United States, people who blithely assume that health care prices are like other consumer goods prices—determined by the forces of supply and demand when lightly regulated consumers freely trade with lightly regulated producers—often make the serious mistake of believing that health care expenditures equal health care costs. While price times quantity still equals health care expenditure, prices in health care are seriously distorted by webs of subsidies, administrative meddling, and interest group politics. They seldom reflect actual costs. If prices do not reflect actual costs, then official expenditures reflect neither the actual cost of providing health care nor the real amount spent on it.

When costs are not the same as expenditures—determining the cost of a hernia repair

Suppose a US doctor says a patient needs a simple inguinal hernia repair within the next 6 months. Usually the patient then schedules the procedure for a convenient date within the next few months, misses work the day of surgery, and spends a day or two recovering. If the patient pays cash, his expenditure on surgery will average \$3,000 to \$4,000. The cost of his surgery includes his expenditure for physician and surgery center services plus travel costs, lost wages, and the value of the time spent

scheduling, enduring, and recovering from the surgery. Additional costs might include any complications from the surgery, which are rare, and the time spent going to surgical follow-up visits.

If the US patient paid cash for his hernia repair at a private, free-standing, outpatient surgery center in a state without certificate of need regulations or excessive taxes on outpatient care, no third party insurer payments would be involved.

Expensive side effects are relatively rare, and as patients can schedule surgery when they need it at a time convenient for them, they have minimal disruption to the daily lives and relatively low costs for pain and suffering. As a result, the expenditure for a cash market hernia repair in the United States is likely to be not too far from its true cost.

Cost and expenditures are much farther apart for patients seeking a simple hernia repair from England's National Health Service (NHS). In 2013, the National Health Service estimated that its average expenditure for uncomplicated hernia surgery was \$2,500.¹⁴ Analysts who mistakenly believe that health expenditure measures true health care costs typically see a number like this, compare it to \$4,000 for hernia repair in the United States, and conclude that the health care costs are lower in England than in America because hernia repairs “cost” \$1,500 less in England.

Unfortunately, the English system imposes high costs on patients and those costs are not included in the \$2,500 National Health Service cost estimate. Though the

While price times quantity still equals health care expenditure, prices in health care are seriously distorted by webs of subsidies, administrative meddling, and interest group politics.

National Health Service provides health care that is free at the point of service to people who meet residency requirements, regional authorities receive annual budgets and have broad authority to decide what health services they will or will not provide in order to remain within their budgets. As they always receive less money than they want, they regularly reduce spending on what they consider to be low value procedures.

Over half of English regional authorities consider simple hernia repair a low value procedure. In order to reduce spending, they will not repair hernias unless patients demonstrate that their hernia causes pain and discomfort serious enough to impede their working life or their day-to-day activities.¹⁵ When individual suffering is sufficient to get approval, people are eligible for surgery after an average additional wait of five months.

Some wait much longer. In 2017, James Taylor had his hernia surgery canceled for the fifth time after he had been waiting for almost a year. Each time he had to fast before surgery, find someone to care for his children, arrange transportation to the hospital, and spend the day waiting. Notification of official cancelation could be as late as 3 pm. Even though he was in “a lot of pain,” and taking daily pain killers while waiting,¹⁶ his regional authority rationed care by providing “only one surgeon available to carry out the operation on a Tuesday morning every six weeks.”

There is no medical reason to delay simple inguinal hernia repair. Most people with asymptomatic hernias will eventually need surgery, and hernias do not get better with watchful waiting. In fact, waiting probably makes things worse. Hernias often increase in size as time goes on, and larger hernias are more likely to recur after surgery.¹⁷ Delaying repair also

increases the risk that someone will need emergency surgery for an incarcerated or strangulated hernia, followed by a hospital stay, substantially more patient pain and suffering, and a mortality rate that is 7 times higher than a simple preventive repair.¹⁸

Are English hernia repairs really less costly? Different people will have different answers depending upon how much they value an extra dollar, an extra pain free day of life, the ability to work with few interruptions, and the lower risk associated with an immediate resolution of their health problem. We know that many people in England think that waiting for National Health Service hernia repair is too expensive even though it is “free.” They opt to forgo “free care” from the NHS, and instead pay cash for prompt, American style, hernia repair at one of England’s private surgical centers.

What is striking is that the price of the same medical product, a cash fee-for-service payment for a simple outpatient hernia repair, is roughly the same in the US and England. In July, 2019, the London Hernia Centre website listed outpatient inguinal hernia repair for £3,710, an all-inclusive price of about \$4,600 at then prevailing exchange rates. When providers and patients are free to make their own arrangements without involvement by third party or government payors, US and English hernia repairs have similar costs.

Reducing official expenditure by delaying drug access

Delaying access to curative drugs is another way government run health care systems shift costs to patients. Solvaldi, a revolutionary treatment for hepatitis C, was released in 2013 at an introductory price of \$83,000 per course of treatment.

Delaying access to curative drugs is another way government run health care systems shift costs to patients.

Despite its cure rate of 90 percent, governments around the world complained bitterly about the high price.

Sovaldi's price was shocking only if one ignored the cost of existing treatments for hepatitis C. A course of the standard existing treatment cost about \$70,000. It had miserable side effects and a much higher failure rate. When it failed, the

only remaining option was a liver transplant at a cost of \$300,000 per transplant and a lifetime of immunosuppressive drugs costing \$40,000 a year.¹⁹

Private coverage plans in the US and Canada did the math and added Solvaldi to their formularies as soon as it came out. The bureaucrats running government health systems balked at the high price citing what it would do to their budgets. Even though hepatitis C infection rates in US Medicaid were estimated to be 7 times the rate in the commercially insured population, and Medicaid covered almost a quarter of the US population, by 2014, 70 percent of Americans taking Sovaldi were commercially insured.

People who mistakenly believe that health care expenditures are the

same as health care costs might conclude that US Medicaid did a better job of controlling costs simply because the growth

rate of its expenditures for prescription drugs was lower than that of private plans. But Medicaid's refusal to pay did not reduce costs. It simply ensured that they would be borne by patients who had coverage from Medicaid but continued to suffer and die because Medicaid provided inadequate treatment.

Reducing official expenditure using waiting lists

In the US and abroad, making patients wait for care is the most visible of the unmeasured costs imposed on people by government and private health care systems that seek to reduce their costs by denying access to care. Waiting lists reduce expenditure because some people die while waiting for care, and some people become too sick to withstand treatment or benefit from it. If waiting lists are long enough, they may also reduce expenditure by encouraging sick people to seek treatment elsewhere. In systems that feature long waits, patients wait to see specialists, wait for diagnostic testing, wait to receive certain drugs, and wait to have surgery. Activists who believe in the superiority of government-run care often try to argue that waiting lists reflect good management because they reduce the costs associated with idle capacity. They ignore the unmeasured costs waiting lists impose on patients.

Strong evidence suggests that waiting for care is expensive. To begin with, people are willing to pay more to avoid waiting. In the US, evidence from Veterans Administration waiting lists and insurance plan choice by elderly veterans who are also eligible for Medicare suggests that a 10 percent increase in VA waiting times increases demand for Medigap insurance by 5 percent. This implies that patients are willing to pay \$300 more in annual premiums to prevent waits of more than 5 days.²⁰

Competition and Drug Pricing

When Sovaldi was approved in late 2013, several drug companies had been working on Sovaldi competitors. Gilead's \$83,000 list price did not last long. By 2015, the average American purchaser paid less than \$44,600 for a course of Sovaldi treatment.

The average European purchaser paid more than \$45,000. Access was limited. France, Germany, Spain, Italy, and the United Kingdom together treated fewer than 158,500 people. American payers treated more than 236,800 people.

Even though its patents had not expired, Gilead announced in late 2018 that it would manufacture generic versions of its hepatitis C cures with a list price of \$24,000 in 2019. Gilead's press release said it believed that a "preemptive move into generics will bring closer together the list price and the actual price that private and government insurers pay today for the branded versions."

Source: Alex Kacik. September 24, 2018. "Gilead to launch generic Versions of hepatitis C drugs," Modern Healthcare, <https://www.modernhealthcare.com/article/20180924/NEWS/180929949/gilead-to-launch-generic-versions-of-hepatitis-c-drugs>

In Britain, where a legal private health care sector exists alongside the National Health Service, an estimated 11 percent of people purchase some form of private health insurance policy so that they have extra cash to buy private health care in cases of serious illnesses, to access to cancer drugs that the National Health Services refuses to pay for, or to eliminate the risk of a life-threatening complication while waiting for NHS hernia repair.²¹

Others simply empty their savings or remortgage their homes to pay cash at private clinics for their care or the care of their loved ones. Those who cannot afford private coverage or cannot afford to pay cash, a significant fraction of people in any high tax low income environment, must either wait or do without.

Government run health systems use a variety of tactics to hide how long people wait for care, suggesting that people in charge of government run systems know that waiting lists impose large costs. Some, like the Denver Health Medicaid program and the US Veterans Administration, simply refuse to acknowledge that any waiting occurs. Others maintain public waiting lists but use a variety of tactics to make waiting times seem shorter than they are. These include ignoring what may be long waits for diagnostic tests and specialist appointments, and measuring only the time spent waiting between specialist referral and actual treatment.

Canada outlaws more private health services than Britain, but its 1984 Canada Health Act did not require coverage of outpatient drugs. Current public coverage of outpatient drugs is skimpy by American standards and often involves waiting. An estimated 25 million Canadians, roughly two-thirds of the population, purchase private health coverage to avoid drug rationing in the public provincial plans.²² This poses

The Denver Health Medicaid Monopoly Waiting List Scandal

In 2006, any Medicaid patient with a Denver address was automatically enrolled in the Denver Health Medicaid Choice Plan. Medicaid would not pay for his health care without an authorization from the Denver Health Plan. Getting authorization required an appointment, and Denver Health had a secret, and illegal, waiting list for appointments that was thousands of patients long. The state paid a monthly fee for each Medicaid client enrolled at Denver Health whether or not he used any medical care.

The state ignored the access problem until Dr. P.J. Parmer, an MD who opened the Ardas Family Medicine clinic in Aurora in 2012, spoke up for his patients. Some of them had been arbitrarily switched to Denver Health Medicaid Managed Care. They could not get appointments at Denver Health, and Medicaid would no longer pay for their health care. They paid cash to see Dr. Parmer, lowering Medicaid expenditure, but they were too poor to afford the drugs and tests he knew they needed. He started a petition. It eventually got the attention of Colorado state Senator Irene Aguilar.

Denver Health blamed its secret waiting lists on new computer systems, reorganizations for improvement, and tight budgets. They still existed when Colorado Medicaid quietly ended automatic enrollment in the Denver Health Medicaid plan in May, 2015.

While Dr. Parmer's patients were unable to get Denver Health appointments in 2013, Denver Health scored 84 percent on the "Compliance Monitoring Tool" Colorado Medicaid used to rate Medicaid contractors. The "tool" used 54 categories to rate a Medicaid contractor. Roughly 10 percent of the categories assessed access to timely, effective, care. The rest focused on measuring Denver Health compliance with various administrative policies and procedures.

Despite its performance, Denver Health received \$81.2 million in supplemental Medicaid payments from the hospital provider fee fund, about 20 percent of total awards in 2018-19. Colorado's private hospitals, which treated Medicaid patients without waiting lists, paid millions more in fees than they collected in supplemental payments.

Melanie Asmar. September 10, 2014. "Medicaid Patients and Doctors are Seeking a Cure for Denver Health's Managed Care," *Westword*, <https://www.westword.com/news/constituents-press-cory-gardner-on-immigration-gun-control-11442634>; Melanie Asmar, May 22, 2015, "Denver Health to Limit Patients Passively Enrolled in Its Medicaid Plan," *Westword*, <https://www.westword.com/news/denver-health-to-limit-patients-passively-enrolled-in-its-medicaid-plan-6738162>; Linda Gorman, November 19, 2014. "Denver Health waiting lists deny Medicaid Patients Health Care Access," *The Gazette* [Colorado Springs], https://gazette.com/opinion/guest-column-denver-health-waiting-lists-deny-medicaid-patients-health/article_f152aa0a-88f4-502a-aca2-62fe74bad498.html

significant problems for the 20 percent of Canadians who have no drug coverage, generally retirees and lower wage workers.

If the goal is to reduce official expenditures, rationing by waiting may reduce surgical expenditure. Some patients die while waiting, and some never receive treatment because they are dropped from the waiting list when their health deteriorates to the point where they are not healthy enough to qualify for surgery.²³ Waiting lists also reduce expenditures by encouraging patients to find alternatives to public care. A significant number of elderly US veterans are eligible for both Medicare and care from the US Veterans Health Administration. Patients waiting for primary care at the VA are more likely to shift to Medicare, reducing the VA's costs without affecting its budget.²⁴

Whether denying access reduces overall spending is an open question. In addition to costs from pain, suffering, and deteriorating health, waiting lists generate costs from lost work time, disability payments, expenses for continuing care provided to the patients on them, and the costs of managing the list itself. Patients who suddenly deteriorate may require emergency care, disrupting hospital operations. In a comparison of data from two pediatric surgical centers in 2002-2003, the waiting time for infant hernia was three times as long in the Canadian pediatric surgical center as in the American one. Canadian infants were more likely to develop incarcerated hernias and need emergency surgery.²⁵

Evidence that waiting lists minimize hospital costs is scant. A study of 137 acute care hospitals in the English National Health Service suggested that from 1998-2002 the level of waiting time that minimized total costs was "always below ten days." At the time, the average waiting time was 103 days, suggesting that

waiting lists were used to ration health care rather than to minimize hospital costs.²⁶

Waiting lists, social trust, and corruption

Waiting lists inevitably induce attempts to get around them. When waiting lists are extensive, favored groups get better treatment both because they can use their influence to jump the queue and because political pressure can ensure that better facilities are located in politically powerful areas. The success that well-connected people have in jumping the queue often creates distrust and hard feelings among those who lack status or contacts.

Data from the Survey of Health, Ageing and Retirement in Europe suggest that people with high levels of education can reduce waiting times for non-emergency surgery by 2.7 months in Sweden and by 25 days in Norway.²⁷ In Australia, public hospital waiting times are strongly influenced by patient socioeconomic status. People with high social status get better treatment, and receive their treatment at better hospitals. The difference is large. The "most socioeconomically advantaged patients are admitted over 4 months sooner than their less advantaged counterparts."²⁸

Attempts to outlaw favoritism may end up adding to overall costs by criminalizing normal human behavior. Sometimes health care workers agree to see people they know and like simply because they are doing a favor for a friend without any conscious intent to help people jump the queue. In Canada, where waiting for health care is pervasive and sensitivity to inequitable treatment is high, Canadian patients have reported normal emergency department triage procedures as unwarranted favoritism.²⁹ They use social networks and connections to get necessary care, and expect Canadian

When waiting lists are extensive, favored groups get better treatment both because they can use their influence to jump the queue and because political pressure can ensure that better facilities are located in politically powerful areas.

physicians to spend their time negotiating with health authorities in aid of efforts to shorten the waits for medical care.³⁰

The most successful attempts to reduce inefficient and socially corrosive waiting lists in Europe and the United Kingdom have combined maximum waiting times with patient choice and competition. Under those policies, patients who wait longer than the target are free to go elsewhere for treatment at the expense of the national health system, exactly the opposite of the type of health system preferred by US supporters of government run health care. It is worth noting that enabling competition and patient choice are policies that are not favored by people who wish to replace US private health care with a government run system.

Why people have better access to care and less waiting in privately run health systems.

Overall health care costs can be reduced by allowing competitive forms of health coverage. When people are willing to pay more to avoid health care waiting, rationing by waiting makes people worse off. If some people prefer coverage that acts like a public system, offering lower premiums in exchange for longer waits, insurers will offer those kinds of policies. If most people will pay more to avoid a wait, most insurers in a competitive market will avoid offering insurance contracts that require policyholders to use providers with positive waiting times.

If an insurer does make people wait more than they like, people will avoid that insurer provided it is possible for a competing insurer to offer a contract with no waiting times for a higher premium.³¹ Unlike most other industrialized countries, the United States had a competitive health insurance market prior to Obamacare. That market is one reason why waiting times in the United States have historically not been a major concern, and why its recorded health expenditures have been closer to its real health care costs than recorded expenditures in Canada and Britain.

In many areas, the Affordable Care Act reforms have eliminated meaningful individual market insurer competition. Indications suggest that waits for care are beginning to be a problem, especially in areas where uncompetitive plans offer narrow networks.³² Given that some Colorado health reformers wish to further reduce patient choice and competition in order to control expenditure, people assessing proposed reforms should pay careful attention to how patients will be affected when private sector wait times rise to match the wait times already reported in Colorado Medicaid.

In many areas, the Affordable Care Act reforms have eliminated meaningful individual market insurer competition.

Part III—How Much Will Replacing Private Control with Government Control Lower Quality and Raise Costs? Government Targets and the Destruction of Traditional Measures of Health Care Cost and Performance.

The Affordable Care Act applied various quality measurement programs on physicians and hospitals, significantly expanding government control over those who supply health care in the United States. Those proposals were designed to change how physicians and hospitals treat patients. They imposed new penalties and rewards to change treatment incentives and to encourage providers to focus on activities satisfying government quality targets. They were generally presented to the public as value-based antidotes to the excessive health care offered Americans by hospitals and doctors in search of profit.

The problem is that ill-considered and poorly tested targets may harm patients. Focus and attention are limited resources, and mandated targets shift focus to the target and away from other, equally important, aspects of patient care. They may also increase health care costs by distorting incentives and encouraging physicians and managers to focus on the targets to the detriment of the patient.

The centrally managed English National Health System has spent decades developing quality targets. Some of the policies have been instituted with much greater penalties for failure and had far greater reach than anything imagined by the architects of the Affordable Care Act. In 2000, the NHS introduced centralized policies to reduce wait times. Colloquially called “targets and terror” by English health system administrators, the new policies had authorities set wait time targets for the whole English health care

system. Failure to meet targets left hospitals open to sanctions. Sanctions were so severe that some senior health administrators lost their jobs.

Waiting lists fell for the first few years. Later in the decade they began rising. English NHS waiting lists are now at all-time highs, and the NHS is considering plans to end its Emergency Department targets.

A “targets and terror” approach will ultimately fail because it gives administrators fearing for their jobs an incentive to game a system they control. Managerial focus moves to hitting a few quarterly targets and away from caring for patients and planning for the future.

Administrators also learn to game the system. An unknown part of England’s initial improvement occurred because providers kept doing the same thing but learned to call it something different. When the NHS began requiring that Emergency Department patients be seen in 4 hours, hospitals responded by moving patients to “clinical decision units, making patients wait in ambulances, admitting patients unnecessarily, discharging people too early, and miscoding data.”³³ Critics argue that the preoccupation with hitting targets encourages people to cut corners to achieve short-term goals, makes meaningful analysis of service development difficult, and subordinates patients to targets.³⁴

English NHS waiting lists are now at all-time highs, and the NHS is considering plans to end its Emergency Department targets.

Academic work focused on using targets to lower expenditure by penalizing the provision of “low-value care” or changing health care payment structures or practice organization usually fails to include complete measurements of either quality or cost. Often it is impossible to measure the most important aspects of a service, and researchers measure quality using whatever markers happen to be collected by administrative systems. Measuring patient costs would require detailed surveys of patients, and they are expensive to conduct.

To understand how poor measurement can alter policy conclusions, consider the claim that managed care reduces expenditures by eliminating unnecessary care. Many of the academic articles claiming to reach this conclusion do so by comparing hospital days. But managed care organizations often control all aspects of patient care, including access to expensive curative therapies. Simply showing that managed care patients spend fewer days in the hospital does not show that managed care reduces costs—it might instead be reducing expenditures by skimping on expensive care and loading costs onto patients or by denying hospitalization to patients who should be hospitalized.

A significant fraction of Medicare Advantage plans are managed care plans that will not pay for any care received without an authorization from a plan’s primary care provider. A number of academic studies show that people who disenroll from Medicare Advantage plans tend to use more medical services after they join traditional Medicare. This suggests that people in Medicare Advantage plans switch to traditional Medicare because they have difficulty accessing the care they need. If that is the case, the lower expenditures reported by the plan may simply reflect large cost shifts to patients.

“Low Value Care:” Wasteful or Risk Reducing?

Imaging for back pain is often cited as an example of “low value care” because the images rarely find anything of note.

Kaiser-Permanente is a health maintenance organization. It seeks to provide health care to its members with the lowest possible expenditure. Physicians in the medical groups that staff Kaiser Plan facilities are financially rewarded if they reduce overall medical spending. Absent so-called “Red flag symptoms,” its clinical guidelines do not recommend imaging in the first 6 weeks of back pain.

In March, 2009, 16-year-old Anna Rahm visited her Kaiser physician seeking an MRI after her chiropractor recommended she get one after suffering weeks of severe back pain. Her Kaiser physician prescribed pain medications and steroids. Two weeks later there was no improvement. Kaiser recommended an epidural, exercises, and changes in diet. Ms. Rahm had numbness in her foot, could not sleep, and discontinued physical therapy due to the pain. Kaiser’s physical therapy department recommended an MRI.

Despite repeated requests, Kaiser physicians refused to authorize an MRI until July 2, 2009. It showed Ms. Rahm’s pain was caused by a fast growing cancer. Her right leg and portions of her pelvis were amputated. Ms. Rahm sued the Southern California Permanente Medical Group. A jury awarded her \$7.2 million dollars for her future medical care and \$5.5 million for lost future earnings.

Lower back pain often resolves without treatment and Kaiser physicians can keep group plan expenditures low by denying MRIs to back pain patients. A few individuals may suffer, but Kaiser physicians do not receive cash incentives for reducing individual suffering. Though Ms. Rahm had symptoms suggesting her back pain was abnormal, she was treated in accord with the plan to keep population costs low. The jury concluded her doctors denied care because they were responding to financial incentives designed to deny reasonable medical treatments to individuals in order to lower group expenditures.

Some people would prefer to pay less in exchange for bearing the risk of harm from a delayed diagnosis. Others would prefer to lower their risk by paying more to purchase faster, more expensive, diagnosis and treatment by physicians who believe them when they report they are experiencing atypical physical pain.

**What if the Quality Target is Wrong?
Colorado Quality Initiative Program Targets
Cesareans, Picks Target Rate Likely to Harm
Babies**

In FY 2010-11, Colorado Medicaid officials listed uncomplicated vaginal deliveries, uncomplicated cesarean sections, and cesareans with complicating diagnoses in the top 10 “cost drivers” for the state Medicaid program. One budget official sarcastically asked if Colorado Medicaid planned to prevent normal births in its effort to lower expenditures.

In 2013, the Hospital Provider Fee Cash Fund Quality Incentive Program decided to make reducing cesarean section rates a hospital quality target by maximizing quality payments for hospitals achieving a 15 percent cesarean rate.

A routine search of the medical literature would have shown that this rate was too low. On average, cesarean rates of up to 20 per 100 live births are correlated with lower maternal mortality. Rates of up to 24 per 100 have been found to lower neonatal mortality and morbidity. No adjustment was made for hospitals with larger fractions of multiple births or older, obese, or diabetic mothers, all groups more likely to need cesarean sections.

Why pick 15 percent? No one seems to know. A 2015 presentation to the Quality Initiative Program cited the American Council of Obstetricians and Gynecologists. But the ACOG emphasized the importance of individualized care. Its editorialists attributed the 15 percent recommendation to the US Healthy People 2010 goals. Other authors pointed to the World Health Organization. Though one Colorado official said that the 15 percent rate was approved by The Joint Commission, it did not publicly report cesarean rates until 2019, and its quality indicator looked for rates over 30 percent.

The Program dropped the cesarean measure after critics pointed out that while its quality target would likely reduce Medicaid spending, it could also end up harming babies and their mothers.

Results like this suggest that before one declares that managed care lowers cost, it is important to determine whether costs have been lowered or whether one is merely observing a reduction in measured expenditures as unmeasured costs are shifted to patients. Though they are generally ignored in policy discussions about quality and efficiency, tradeoffs between timeliness, convenience, and long-term outcomes are important to patients. Difficult to measure and almost impossible to account for when institutions rather than patients control care, they are one reason why health care costs so often increase when government run systems displace private controls.

The problem, as economist Charles Goodhart has observed, is that when a performance measure becomes a target, it ceases to be a good measure. When patients control funding, professional societies dependent on patient revenues often developed guidelines of the qualities exhibited by groups that delivered medical care of reasonable quality. When government controls funding, those guidelines are often used to control payments. Providers make sure that they perform well on the payment target even if other aspects of patient care suffer, and the over-dependence on a single quality measure ends up harming patient care.

Medicare is fertile ground for examples of how the application of targets can distort patient care. When Medicare officials decided to allow private managed care companies to provide all health care for beneficiaries in exchange for an annual fee under the Medicare Advantage program, they began by paying Medicare Advantage plans 95 percent of the average annual amount spent treating an average beneficiary in the traditional fee-for-service Medicare program. The managed care plans quickly realized that they could maximize their returns by making

themselves more attractive to people likely to be low cost because they were in better than average health, and less attractive to people likely to be high cost because they were in worse than average health. Medicare officials realized what was going on, and after 1997, Medicare began using diagnostic codes to assign a risk score to each Medicare beneficiary. The more comorbidities a patient had, the riskier he was. Patients with higher risk scores generated higher annual payments to Medicare Advantage plans even if they used the same amount of health care as lower risk patients.

By using the diagnoses in medical records to determine annual payments, Medicare made patient records into managerial targets and, as Charles Goodhart predicted, recorded diagnoses ceased to be accurate measures of patient health. In traditional Medicare, when a patient receives a treatment, his diagnosis is added to his medical record. Those who treat him have little incentive to report anything other than the diagnosis that generated the procedure that was billed for, because they only get paid for the treatments received. In Medicare Advantage, entering more diagnoses into a patient's record may increase the patient's risk score. As a higher risk score increases a plan's annual payment, Medicare Advantage plans have a strong incentive to carefully examine their patients and record every diagnosable condition they find.

By 2010, the Government Accountability Office estimated that Medicare Advantage "beneficiary risk scores were at least 4.8 percent, and perhaps as much as 7.1 percent, higher than they likely would have been if the same beneficiaries had been continuously enrolled in fee-for-service. The higher risk scores were equivalent to \$3.9 billion to \$5.8 billion in payments to MA [Medicare Advantage] plans."³⁵ In 2014, Kronick and Welch

looked at the risk scores for all Medicare beneficiaries from 2004-2013. They found that risk scores for people in Medicare Advantage increased more rapidly than risk scores for people in traditional Medicare. There was no evidence that the change in coding intensity could be accounted for by changes in patient case mix. Coding intensity also varied widely across Medicare Advantage plans, leading Kronick and Welch to conclude that it will "be challenging to devise optimal policy responses." No one knows if Medicare Advantage plans were "overcoding" or traditional Medicare fee-for-service was "undercoding" because no one knows the value of examining for, and finding, untreated health conditions. What is known is that making diagnostic coding a payment target reduced its usefulness as a measure of overall patient health.³⁶

The Hospital Readmissions Reduction Program (HRRP), one of the quality improvement programs created by the Affordable Care Act in 2010, provides another example of how the imposition of government performance targets can degrade patient care. The program sought to improve hospital performance by targeting "preventable" hospitalizations. It imposed financial penalties on hospitals with higher than expected 30-day readmission rates for heart failure, heart attack, and pneumonia. The penalties were large, up to 3 percent of Medicare reimbursements when, in 2018, the median nonprofit hospital's operating margin, the "profit" on each dollar of revenue that is left over after paying for everything needed to care for patients except interest and taxes, was just 1.7 percent and a sustainable operating margin was estimated to be around 2.5 percent.³⁷

The Hospital Readmissions Reduction Program's (HRRP) incentive design also ignored the fact that death is recorded as

The Hospital Readmissions Reduction Program (HRRP), one of the quality improvement programs created by the Affordable Care Act in 2010, provides another example of how the imposition of government performance targets can degrade patient care.

Perhaps the most important lesson of HRRP is that after 8 years of operation, no one knows whether a government run program that shifted billions of dollars of public and private money from standard inpatient care to reducing readmissions has achieved the results its creators intended, whether it encouraged hospitals to skimp on inpatient care, or how it has affected overall health costs.

a discharge, and a dead patient cannot be readmitted. It defined readmissions as inpatient hospitalizations. Observation stays and emergency department visits were not considered readmissions. The program did not adjust for the severity of illness, changes in case coding, or patient social factors known to be independently associated with readmission. These oversights combined to create a system of incentives in which hospitals managing to keep more sicker, frailer, or disadvantaged patients alive, even though they might be readmitted at higher rates, were more likely to be penalized than hospitals in which those people were more likely to die. To make matters worse, the penalties for high rates of readmissions were higher than the Medicare penalties for high in-hospital mortality.

Though supporters declared HRRP a success because its targeted readmissions fell,³⁸ there is considerable debate over whether the decline was a statistical artifact. Some of the decline may have occurred because US hospitals reacted to US government imposed targets just like government run National Health Service hospitals reacted to British government imposed targets—they gamed the target to take care of patients who were sick and needed readmission. Rather than admitting patients, they treated them with emergency department visits and lower intensity observation stays, which explains why total hospital revisits did not change.

But as hospitals responded to HRRP penalties by skimping on readmissions, the change to lower intensity observation stays and outpatient treatment may have increased the risk of death for heart failure patients. In 2019, Wadhera *et al.* studied the results and concluded that “mortality within 30 days after discharge from a hospitalization for heart failure increased significantly after implementation of the HRRP.” The increase was concentrated

among patients who were not readmitted.³⁹ While HRRP architects did succeed in changing hospital behavior by placing restraints on physicians and patients who sought readmission, the changes they engineered appear to have been lethal for some heart failure patients. Had patients been given the choice, some may have preferred to pay less in exchange for a higher risk of death. Others would likely have been happy to have paid more.

Much of the readmissions reduction observed after HRRP may simply have reflected long-term improvements in medical care. Samsky *et al.* compared 30 day readmissions for heart failure patients in US and Canadian hospitals from 2005 through 2015. They found that the decline in US and Canadian readmission rates for heart failure patients was unchanged over the decade. Canadian all-cause readmissions decreased by 1.1 percent per year before 2012, and 1.3 percent after. US all-cause readmissions decreased by 1.6 percent per year before 2012 and 1.8 percent per year after. They conclude that this suggests that “the implementation of financial payment penalties in October 2012 under the HRRP may not have had as large an influence as was previously thought.”⁴⁰ In the US, 3.8 percent of heart failure patients died during their initial hospitalization and so were not candidates for readmission. In Canada, 9.9 percent of patients died.

Perhaps the most important lesson of HRRP is that after 8 years of operation, no one knows whether a government run program that shifted billions of dollars of public and private money from standard inpatient care to reducing readmissions has achieved the results its creators intended, whether it encouraged hospitals to skimp on inpatient care, or how it has affected overall health costs. It does show that the top down imposition of managerial targets so often favored by politicians and other

government managers are unlikely to produce good overall results. Health care is a complex system, and it was irresponsible of government officials to impose such a large change without first implementing a properly controlled pilot program to test for unintended consequences. As Jha pointed out in a 2018 JAMA commentary, HRRP shifted incentives so much that

...a high-readmission, low-mortality hospital will be penalized at 6 to 10 times the rate of a low-readmission, high-mortality hospital. The signal from policy makers is clear—readmissions matter a lot more than mortality—and this signal needs to stop. If patients understood what policy makers were doing, they would be outraged.⁴¹

Targets, skimping, and gaming in the individual insurance market

While HRRP likely led to skimping on hospital care for heart failure patients, government managers promoting the simple fixes ingrained in the Affordable Care Act have led to general health care skimping in the individual insurance market. The ACA required insurers to ignore health status in setting premium rates for coverage, and to issue policies regardless of health status. It ended the longstanding market practice of requiring people to pay more for coverage if it was known that their state of health was likely to generate higher medical costs for those who had already purchased individual coverage.⁴²

By outlawing pricing differences for medical risk, the Affordable Care Act reduced the incentive to provide coverage for people with known health risks. Many individual insurers simply left the market. The ones who remained immediately began gaming the new system by seeking ways to make their health plans less

attractive to the sicker people who were likely to cost them money. They began dropping specialists, endocrinologists, rheumatologists, and psychiatrists, from their physician networks to make them unattractive to people with diabetes, autoimmune diseases, and mental illness.⁴³ They also excluded National Cancer Institute designated cancer centers from their hospital networks, did not contract with the academic medical centers likely to be essential to people with more complex health problems, and refused to do business in markets with more expensive members.

On the demand side of the market, the Affordable Care Act's insurance regulations encouraged people buying policies to behave in ways that have destabilized the individual insurance market. Most individual insurance contracts sold in the United States before the Affordable Care Act guaranteed that people could renew their policies regardless of their health status, and that a policyholder would not be charged higher premiums because he had been sick. The technical name for this is guaranteed renewable at class average rates. An individual's premium would rise only if premiums rose for everyone, healthy or not, in the insured's "class."

To pay for the guaranteed renewability, insurers charged more than they expected to pay out for the first few years of premiums, a practice called front loading. A portion of the payments was set aside as a reserve to cover the costs of people who unexpectedly incurred larger than expected medical claims. As the front loading period ended, people who had purchased the same policy for years had an incentive to keep renewing it because their renewal rates were less than the rates that would be charged if they switched companies and had to pay another few years of front loaded premium.⁴⁴

By outlawing pricing differences for medical risk, the Affordable Care Act reduced the incentive to provide coverage for people with known health risks.

Without front loading, buyers with chronic conditions and predictable medical needs have an incentive to purchase a policy, compress the health care they need into a few months, and cancel the policy after a few payments. Data from California show that untraditional health insurance purchasers, generally people encouraged to buy coverage by the Affordable Care Act subsidies, timed their health spending to compress their annual spending into a relatively short period. Once they received the health care they wanted, they stopped paying premiums and dropped their plans. This occurred at every income level. In 2014, 15 percent of households dropped coverage after 1 month, 41 percent of households dropped coverage by July, and 50 percent dropped coverage by the end of the year.

Reducing welfare by limiting access to coverage that people need

Affordable Care Act reforms have also limited individuals' ability to tailor coverage choices to their needs. Estimates from employer subsidized plans show that people with family plans will pay up to \$400 a month for broader networks if those networks include their usual sources of care. People with riskier health status, those likely to know the most about getting medical care they need, are willing to pay even more. Even in California's Affordable Care Act exchange, where plans are standardized and customers have lower incomes, households are sensitive to network adequacy and are willing to pay more to access bigger networks.⁴⁶

After the Affordable Care Act passed, many state regulators outlawed the limited benefit policies preferred by low income people dependent on hourly wages because those policies failed to satisfy the ACA's policy requirements.⁴⁷ The people who designed the Affordable Care Act modeled its plan requirements after the rich plans offered by large, self-insured, employers who generally paid well and funded their plans with pre-tax dollars. But people who have few assets, small cash flows, and incomes that stop if they cannot work get little protection from ACA policies. If they cannot work their income drops to zero, making them eligible for Medicaid in many states, and as \$6,000 worth of bills will bankrupt them, paying premiums for an ACA policy is a lot like paying for no insurance.

Before the Affordable Care Act, employers with many low-income workers often provided plans tailored to the needs of the people who worked for them. In exchange for small premium payments, people could buy "mini-med" plans: policies with small deductibles and total plan benefits capped at amounts

The evidence suggests that many of the newly insured mid-year dropouts used their subsidized coverage to get someone else to pay for their less urgent medical care.

The evidence suggests that many of the newly insured mid-year dropouts used their subsidized coverage to get someone else to pay for their less urgent medical care. Traditional purchasers, the households maintaining full year coverage, ended up paying far more than necessary because everyone's premiums were increased to make up for the losses generated by the opportunistic users.⁴⁵ When combined with its ban on pricing coverage according to medical risk, the Affordable Care Act's lavish premium subsidies enabled people to take advantage of those who purchased individual coverage for a whole year. Responsible people ended up paying higher premiums and taxes so that others could game the individual insurance market subsidies and enjoy lower cost, nonurgent care. Government officials have shown little concern for the 10 million people damaged by the Affordable Care Act's destructive effect in the market for individual insurance. They want to be able to claim that the ACA has increased coverage and do not appear to be particularly concerned about this kind of health care cost increase.

like \$25,000 or \$50,000. Though those benefit amounts were low compared to the \$1 million to \$3 million caps on large employer policies, they were a good bet for people who did not have large amounts to spend on health insurance because most people have moderate medical expenses. In 2013, fewer than 5 percent of non-institutionalized Americans had annual health expenditures above \$19,000, an amount well within the payment capabilities of mini-med plans.⁴⁸

Substituting government payments for private payments under the Affordable Care Act stripped control from patients and put third party government or private authorities in control of health care payments and the basket of services that would be covered. It made it much harder for people to get the medical care they needed on financial terms that suited their circumstances. It also generated

unintended consequences that increased unmeasured costs and created a complex system with much less accountability. Freeing people to determine the kind of health care they want to purchase and giving them the power to decide how to finance it would improve accountability. If providers or insurers provide an unacceptable combination of cost and quality, patients and customers can instantly penalize offenders by withdrawing their funds and going elsewhere.

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Part IV—Pricing, Innovation, Global Budgets, and Fee for Service: How Will Proposed Changes Alter Incentives in Ways that Affect Patient Welfare?

When government payments are substituted for individual payments, tax money continues to flow into government run health programs even if they fail to achieve their stated objectives or provide the type of health care and health care financing that the people using them would prefer. Governments have limited incentives to change the way they do things. They are slow to adopt useful innovations and slow to discard innovations that do more harm than good. People who have grown accustomed to government cash strenuously resist attempts to take their cash away, officials are loath to admit that their programs are ever failures, and those who set up

the failed program seldom face any accountability for their lapses in judgment. Vested interests and interest group politics make it difficult to end marginally effective programs, and the denizens of the regulatory swamp are expert at using complex administrative procedures to block innovations that threaten the incomes of existing providers.

Incentives under global budgets

Government run health facilities often operate under a global budget, an arrangement in which national, regional, or local providers receive a budget for providing health care during a given

Profits and Freedom to Innovate Drive Development of Ambulatory Surgery

Steady progress in new analgesics and minimally invasive surgery had made outpatient surgery possible when Dr. Charles Hill opened the first modern freestanding surgery center in the US in Providence, Rhode Island. It failed. W. A. Reed and J. L. Ford opened the first successful freestanding surgery center in Phoenix in 1970 after enlisting cooperation from major insurers and Medicare

Hospitals lobbied against the new centers because the competition reduced their revenues. But third party payers liked the lower costs at the free standing centers, patients liked recovering at home, and surgeons liked the increased productivity and income that came from a facility built to maximize their throughput.

By 1985 there were 459 freestanding surgery centers in the US doing nearly 800,000 procedures a year. Eighty-one percent of hospitals were forced to respond to the competition by opening their own outpatient surgery centers. Hospital outpatient surgery was 28 percent of all hospital surgical procedures.

Adoption of ambulatory surgery was slow to develop in Britain because government controlled hospitals operating under global budgets had little incentive to change. Though some British physicians had published on outpatient surgery as early as the 1950s, by 1986, only 17 percent of British general surgeries were done on an outpatient basis.

Source: Detmer DE, Gelijns AC. Ambulatory Surgery: A More Cost-effective Treatment Strategy? *Arch Surg.* 1994;129(2):123-127. doi:10.1001/archsurg.1994.01420260009001; Morgan M and Beech, R. 1990. "Variations in Lengths of Stay and Rates of Day Case Surgery: Implications for the Efficiency of Surgical Management. *J Epidemiology and Community Health*, 44, 90-105.

period. The health facility must decide how to allocate its resources across the different kinds of health care it provides. Advocates for global budgets in the United States contend that they reduce expenditures because they force providers to control costs by making wise choices about what they will treat and how they will treat it.

The basic problems with global budgets are that the people deciding on their size have no idea how valuable health care is to the people receiving it, and the facilities receiving the money do not have to be responsive to patients. In Canada, for example, the government funds too few long-term care beds. This creates a backlog in hospitals, because hospitalized patients who need nursing home care have no place to go and remain in place, blocking new patients from being admitted.⁴⁹ With no beds available, emergency departments cannot admit new patients, and physicians with hospital patients who do not need long-term care are pressured to discharge patients before they are ready. Emergency departments are also overburdened by the fact that an estimated 13 percent of Canadians have no family physician in a country in which the health care system requires either family physician or emergency department authorization to access health care.

As the government providing the money is the customer, providers receiving global budgets are responsible to the politicians that fund them. Providers can easily ignore patients, making choices that are wise for themselves, but suboptimal for patients, while loudly claiming that they are doing the best they can with limited resources. Health care facilities funded by global budgets often find it easier to "block inflow and leave patients in a queue" than to change the way they do business. This limits accountability and "displaces the consequences of access failure to other,

more remote, parts of the healthcare system.”⁵⁰ If patients do complain, officials can scare them into submission by threatening access. People are also frightened into submission by threats of closure, and by claims that they will not be able to afford care if they are required to start paying for care at the point of service rather than through the tax system and global budgets.

In the United States, the Veterans Administration is the largest health system operating under a global budget. Like almost all of the other systems operating under a global budget in the rest of the world, the VA has waiting lists, deteriorating facilities, sub-par health care, and a long history of health care scandals. Though reforms have been promised for decades, little has changed. The veterans the VA is supposed to care for must take what it decides to give or go without care, and the Veterans Administration gets its money no matter what it does. Politicians who threaten to impose penalties or budget cuts are rapidly brought to heel when the VA strategically responds by simply denying care to veterans, pointing to budget cuts as the problem, and accusing officials of neglecting America’s veterans.

Outside of the Veterans Administration, most US health care facilities operate on a fee-for-service basis. Under fee-for-service, providers are paid for the services they provide. If they provide more services, they get paid more. The incentive to deny treatment to sicker patients who are more expensive to treat is eliminated because hospitals and physicians get paid more if they provide more treatment. Because more productive people and institutions can earn more, fee-for-service also gives physicians and hospitals a strong incentive to innovate and invest to make their services more productive and more attractive to patients. The signals provided by profits and losses encourage

people to expand treatment capacity as demand grows, add new components if they are needed, and abandon unnecessary facilities.

Advocates for global budgeting routinely claim that fee-for-service systems cause high health care spending because they give physicians and hospitals an incentive to provide more care than necessary. The question is whether this incentive is strong enough to override professional responsibility and the administrative systems that both government and private sector providers use to find and eliminate it. The fact that most people dislike undergoing medical procedures also dampens the ability to provide unnecessary care. People resist even necessary care, and many of the same groups calling for government intervention to reduce unnecessary care also want government to act to boost consumption of recommended care.

Studies claiming that the US has an epidemic of unnecessary care define it in a variety of ways. Whether a medical treatment is necessary depends upon who receives it, when it is received, and the reason it is provided. A treatment or service that is of low value in some clinical circumstances may be of high value in others. To make matters even less clear, opinions about the value of various treatments routinely change as medicine progresses and more information becomes available. In 2012, the influential US Preventive Services Task Force (USPSTF) recommended against prostate-specific antigen (PSA) blood tests for prostate cancer, instantly transforming them into low value care. In 2018, the PSA test was taken off the low value list when the USPSTF recommended that physicians discuss the risks and benefits of PSA testing with all men ages 55 to 69. The new recommendation instantly made the US health care system more efficient. It

If patients do complain, officials can scare them into submission by threatening access.

reduced the amount of “wasteful” care used by men who, in consultation with their physicians, had ignored the earlier USPSTF recommendations and continued to use the information provided by a PSA test to reduce their individual risk of dying from undiscovered prostate cancer.

Many of the studies cited as evidence for an epidemic of unnecessary care provide weak evidence about its extent because they were not designed to capture the information in medical records that gives the who, when, and why of the clinical circumstances that may transform unnecessary care into necessary care. Studies of wasteful care often use more easily accessible insurance claims data. This, along with constantly changing opinions on what is and is not wasteful, means that wasteful is often in the eye of the beholder, and estimates of it should be viewed with a certain skepticism. For example, some studies of low value care include PSA screening for prostate cancer outside of specific age groups in their low value lists.⁵¹ But a growing body of evidence suggests that baseline PSA levels are stronger predictors of future prostate cancer risk than either race or family history, making them useful for informing future cancer screening strategies for younger men.⁵² In a 2016 review of the literature, de Vries *et al.* examined the evidentiary backing for 115 low-value care measures. They concluded that only three were “underpinned by both guidelines and literature evidence. For other measures, such a level of evidence was not transparently apparent.”⁵³

Advocates for global budgets also ignore how the different incentives in global budgets and fee-for-service (FFS) care affect patient treatment. The payment incentives providers face under global budgets are similar to those faced by US health maintenance organizations (HMOs). In both cases, providers receive

a fixed annual payment in exchange for promising to provide all necessary health care. In the US, such payments are often called capitated payments because providers receive a fixed amount per patient. As the US has a variety of payment systems, many of the studies of the incentive effects of different payment structures compare outcomes for US patients under fee-for-service and capitated payment arrangements. If HMO enrollees are healthier at baseline, naïve comparisons will generally show that capitated systems reduce expenditure without affecting health. The results change when researchers account for differences in enrollee health. It is difficult to adjust for differences in baseline health and individual behavior. Results from various comparisons remain suggestive rather than conclusive. Another major difference is that while there is no escape from a national global budget, many US patients can enforce a minimum level of care on providers by switching insurers or dropping coverage and planning to finance their health care with cash payments.

When state of health is accounted for, sicker patients may have better outcomes when they are treated under fee-for-service arrangements. A 2000 *Cochrane Database* study of the behavior of primary care physicians concluded that FFS resulted in more primary care visits/contacts, visits to specialists, and diagnostic and curative services, compared to care under capitated plans, along with fewer hospital referrals and repeat prescriptions. Compliance with recommended visits was higher under FFS, but patients were less satisfied with access to their physician. For Americans aged 55 to 64 with employer provided health plans, Xu and Jensen found that enrollment in a health maintenance organization was associated with more functional limitations for people with chronic conditions.⁵⁴ Kramer *et al.* concluded that one year after having a stroke, elderly patients enrolled

When state of health is accounted for, sicker patients may have better outcomes when they are treated under fee-for-service arrangements.

in Medicare HMOs had poorer functional outcomes, and were more likely to reside in a nursing home, than patients treated under Medicare FFS arrangements. The difference in outcomes was consistent with the fact that HMO patients received lower intensity treatment.⁵⁵

Studies comparing outcomes in US Medicare's fee-for-service and capitated Medicare Advantage programs find that Medicare Advantage plans skimp on expensive procedures such as coronary angiography after a heart attack,⁵⁶ and that stroke patients treated in Medicare Advantage were more likely to reside in nursing homes one year after a stroke. Medicare Advantage patients may also be admitted to lower quality skilled nursing facilities and receive lower intensity care.⁵⁷ Data from other countries, and controlled experiments, suggest that the fee-for-service system encourages physicians to provide more direct patient care. It may be that patients who need high levels of medical services receive larger benefits from fee-for-service while patients who need lower levels of medical services are overserved by fee-for-service and find that level of services provided by capitated care systems better serve their needs.⁵⁸ Evidence from changes in Medicare payment rates further suggests that physicians' investments that increase their long-run capacity to treat patients responds to changes in their practice's long-run profitability. If lower reimbursements reduce future profitability, physicians may respond by reducing their acceptance of new patients.

In 2011, the Canadian Health Services Research Foundation reviewed the effects of global budgeting in the Canadian health care system. It urged adopting more fee-for-service funding in order to better reflect the type and volume of services hospitals provided. It concluded that global budgeting contributed to

Canadian hospital problems because it did not provide incentives to improve hospital care access, quality, or efficiency. Based on historical spending, inflation, provincial negotiations and politics, rather than on the type and volume of services patients needed, global budgets made it difficult to keep up with technological and demographic changes. The tradeoff was a familiar one: while global budgets did constrain hospital spending growth and create budgetary predictability, they decreased the services offered and increased waiting times.⁵⁹ The lack of additional payment for additional work under global budgets may also reduce physician productivity. In 2005/06, English general practitioners worked 44.4 hours per week. In 2003, general practitioners in the US worked 51.4 hours per week. In 2005/06, English specialists worked 50.2 hours per week. US specialists worked more, averaging 54.3 hours per week in 2003.⁶⁰

Why does fee-for-service work better for sicker patients than global budgets or a single flat fee for each patient? The British call it the "efficiency trap." Under global budgets, hospital administrators view sicker patients as an added expense simply because they simply cost more to treat. Any administrator funded by a global budget and interested in staying under budget knows that having a population of healthier patients improves his bottom line. As patients spend longer in the hospital and their health improves, it costs the hospital less and less to provide a day of care.

The problem is that when a hospital discharges a long stay patient, it substitutes a high cost new patient for a low cost recovered one. Given the incentives, a hospital operating under a global budget will prefer to put low cost, long stay, patients in its beds rather than high cost, short stay, acutely ill ones. A hospital that

The tradeoff was a familiar one: while global budgets did constrain hospital spending growth and create budgetary predictability, they decreased the services offered and increased waiting times.

gets paid on a fee-for-service basis has an incentive to move low cost patients out of its beds in order to make room for acutely ill patients who need more services and generate higher payments.

Global budgets make innovation less attractive than fee-for-service because there is little to gain from innovations that do anything other than reduce cost, and no way to be paid for the disruptions that change always generates. In 1994, the lack of reward for incurring the risk of change was cited as one of the reasons why “hospital administrators and physicians in European countries had been reluctant to adopt ambulatory surgery.” Government run health systems moved to contracts requiring cost and price competition and “focus[ing] attention on the advantages of ambulatory surgery” to increase its use only after public pressure over waiting lists encouraged national planners to move from global budgets to activity-based funding.⁶¹

The US has historically had a competitive hospital system that operates under a fee-for-service, activity-based, model. In order to attract private pay fee-for-service physicians, and the patients they refer, many private US hospitals have remodeled their facilities, paid close attention to the

quality of ancillary staff, and added high cost equipment that improves employee productivity. Though the growth of single rooms in US hospitals has likely increased US health spending relative to countries that have not upgraded their hospitals, it may also have made patients better off by reducing noise, improving sleep, promoting rapid healing, and fostering better infection control. The cost of building and staffing single rooms is relatively simple to measure. The benefits for patients are much more difficult to quantify.

Increased spending on hospitals may also improve patient safety. The accompanying table shows estimates of inpatient errors in the US and government run health care in three countries. When government is both provider and regulator, accurate patient safety reporting requires that government accurately report on and penalize its own deficiencies. Table 4 suggests that expecting good outcomes from this kind of system may be expecting a little too much.

Global budgets make innovation less attractive than fee-for-service because there is little to gain from innovations that do anything other than reduce cost, and no way to be paid for the disruptions that change always generates.

Table 4: Does Higher Spending Buy Safer Hospitals? Hospital Inpatient Mistakes by Country

	Percentage of patients with at least one adverse event	Percent of adverse events contributing to death
New Zealand (2002), Davis	12.9	4.5
Britain (2001), Vincent	10.8	8.2
Canada (2004), Baker	6.8	15.9
US (2000), Thomas	3.2	6.6
Source: de Vries et al. 2007. The incidence and nature of in-hospital adverse events: a systematic review. <i>Quality Safety in Health Care</i> . 10.1136/qshc.2007.023622;		

Part V—Does the US Spend too Much on Health Care or do Other Countries Spend Too Little?

According to the OECD, the US currently spends about 17.2 percent of its GDP on health care. Many people argue that 17.2 percent is too much. The British have held health spending to just 9.8 percent of GDP. Those who believe that limiting health spending is an important policy goal urge that US governments act to force Americans to spend less. Some would prefer a British or Canadian structure in which government decides how much will be spent on health care, collects taxes to fund it, dictates how health care will be delivered, decides on allowable treatments, owns health facilities, and hires and fires the staff.

Britain's National Health Service (NHS) provides medical care that is free at the point of service to all who are ordinarily legal residents of the United Kingdom. As the British population is both growing and growing older, the Institute for Fiscal Studies estimates that Britain must increase its health budget by an average of 3.3 percent per year over the next 15 years just to maintain the status quo.⁶² Staffing costs account for more than 60 percent of expenditures, and pay increases for physicians and nurses have been below the inflation rate since 2010. In 2015, specialist doctors in the United Kingdom made 3.4 times the wages of the average worker. Salaried general practitioners made 3.1 times the average wage. In Canada, specialists and GPs earned 4.5 and 2.8 times the average wage.⁶³ In 2011, US hospital nurses earned 1.3 times the average wage, just behind the 1.4 times in Luxembourg and Greece. UK hospital nurses earned 0.9 times the average wage.⁶⁴

Maintaining the status quo means accepting lower health care quality.

Because the NHS is large, expensive, and in competition with every other government spending priority, the British government has systematically underfunded it. Spending increases of 3.7 percent a year have been the average increase since the NHS was founded. In the decade after the 2008 economic crash, the budget rose by an average of 1.5 percent each year. In fiscal years 2017-18 and 2018-19, when politicians have promised to restore NHS spending, inflation-adjusted spending growth has been 2 percent per year.⁶⁵

Even with the 2 percent increase, there is never enough money to finance current spending. Like many government-run organizations, the NHS uses its staff inefficiently and it has difficulty recruiting and retaining qualified people. In 2018, an estimated 1 in 11 jobs was unfilled. In nursing, an estimated 1 in 8 jobs was unfilled. The number of general practitioners is falling, and the NHS in England has an estimated 2,500 fewer full-time equivalent GPs than it currently needs. That gap is projected to grow to 7,500 by 2028/9.⁶⁶ Staffing is so poor in Emergency Departments that an estimated 1/3 of NHS emergency department physicians emigrated abroad between 2010 and 2015.⁶⁷ Part of the problem is that the constant search for more tax revenue led to a 2016 change in tax law that targeted the savings of people eligible for public pensions. An unintended consequence of the law was the creation of marginal tax rates of over 100 percent for many senior physicians. They responded by retiring or reducing their working hours by 10 to 15 percent, further exacerbating the NHS physician shortage.⁶⁸

Like many government-run organizations, the NHS uses its staff inefficiently and it has difficulty recruiting and retaining qualified people.

British cancer outcomes have long been inferior to those in comparable countries, people wait months or years for specialty care, and elderly people are denied cataract surgery.

In government officials' unending search to find more revenue for underfunded health programs, capital budgets are an attractive target. The effect of reducing spending on plant and equipment can be hidden for long periods and may not show up until current officials are long out of office. British planners sometimes increase current spending by raiding NHS capital spending budgets. Capital spending was reduced 21 percent between FY 2010-11 and FY 2017-18. This created a large backlog of deferred maintenance and substantially reduced the purchase of new medical facilities and equipment. As increased capital spending is vital to increasing a medical system's ability to handle more patients, the capital spending cuts shifted substantial unmeasured costs onto British patients.⁶⁹ Since Fiscal Year 2012-13, waiting lists for non-urgent care have grown by 1.5 million patients, and performance against the standards the British government uses to measure health system performance has relentlessly deteriorated. British cancer outcomes have long been inferior to those in comparable countries,⁷⁰ people wait months or years for specialty care, and elderly people are denied cataract surgery. Those who can afford it are giving up on the NHS and turning to private providers. In 2018, private medical care providers reported a 53 percent rise in the self-pay market in four years. It was driven by "very high waits for NHS diagnosis and treatment," with high volumes in hip surgery and cataract operations.⁷¹ Patients in government-run systems have no recourse when they must pay cash to get the services that their government was supposed to provide in return for much higher taxes.

Saving Cost or Saving Lives?

Advocates urging that US governments limit health spending to the fractions of GDP devoted to health in Canada,

England, and Europe generally fail to explain the tradeoffs implicit in meeting such an arbitrary spending goal. Sometimes technological developments in medicine reduce health spending, as when new vaccines are discovered, or advanced imaging reduces exploratory surgery. Sometimes medical progress increases expenditures. Discovering insulin saved people from horrible deaths, but significantly increased health spending because keeping people alive requires a lifetime of treatment with expensive drugs.

In the US, diabetes increases health care spending by about \$8,000 per diabetic per year. One way to reduce expenditures would be to return to 1930s protocols for all diabetic patients. The new insulins and the equipment needed to tightly manage blood glucose are much more expensive than older drugs and techniques. But early treatments were too imprecise to prevent chronic complications such as kidney failure, blindness, and nerve damage, and some people had allergic reactions to insulin derived from cow and pig pancreases.

Diabetes treatment in the US is routine only because people want to spend more on medical care for diabetics and can afford to do so. In Zambia, a rural child with diabetes requiring insulin treatment has a life expectancy of roughly 7 months even though pharmaceutical companies provide insulin for just 20 percent of the price they charge in the industrialized countries.⁷² If lowering expenditures is the only policy goal that matters, why not imitate Zambia?

As this shows, people who preface their remarks by "the US spends too much on health care" need to explain how much they believe it should spend and why they believe their number is the correct one. Often people recommending lower spending are relatively young and healthy.

They value medical care less than those who need it, and they seek to impose their preferences on others. Often people intent on reducing spending have little experience with health tradeoffs or have not given the matter much thought.

Those recommending arbitrary spending cuts routinely deny that their proposed cuts will harm patients. Instead, they say that they are cutting waste. In their view, US health spending waste makes up most of the difference between US spending and British or Canadian government run health spending, and they believe that it is a simple matter to identify and eliminate waste.

The problem is that what is waste to them may be essential health care to others. Strong evidence suggests that what any individual thinks “should” be spent on his health care depends on his income, his state of health, his age, his attitude towards risk, and his personal preferences. Attempts to impose one person’s preferences on everyone else is both inhumane and doomed to failure.

The rankings of procedures given by the Oregon Health Authority show the large difference between what individuals think medical dollars should be spent on and what committees running government health systems choose to spend them on. In 1993, the Oregon Health Authority began ranking medical procedures according to their value for the purpose of guiding explicit rationing in the Oregon Medicaid program. After a major methodological change to the ranking protocol in 2006, there were large changes in the ranking priorities.

As one would expect given that governments tend to focus on population health rather than individual health, Oregon’s Health Authority generally ranked treatments aimed at improving population health higher than treatments devoted to treating relatively small numbers of seriously ill individuals. In 2009, the rapid and complete treatment of medically correctable conditions were considered lower priorities than routine care for pregnant women (rank 1), newborns (rank 2), and preventive services for children (rank 3 and 4). In 2002, the value of treatment for a hernia with obstruction and/or

Cancer Screening Choices: Your Money or Your Life?

Cancer screening increases health expenditures. Government run health care systems typically economize on cancer screening because the cost of screening people is higher than the value health planners assign to the lives saved.

In a 2009 article in *Health Affairs*, Howard *et al.* reported that in 2004, 77 percent of US women had had a mammogram within the last 2 years. In the government-run systems of Europe, only 46 percent of women had been screened. For colon cancer, 60.6 of Americans aged 65 to 74 had been screened. In Europe, the figure was 26 percent. Screening for Pap Smear and Prostate-Specific Antigen tests were also much lower in EU countries.

Like their European counterparts, US planners sometimes seem more concerned with saving money than saving lives. In 2009, the U.S. Preventative Services Task Force recommended against routine screening mammography in women aged 40 to 49 years due to evidence that the net benefit was “small.”

In a 2009 paper in the *Annals of Internal Medicine*, Mandelblatt *et al.* estimated that biennial mammograms reduce the risk of dying from breast cancer by 1 to 6 percent in 40 to 49 year old women. It reduces the risk by 15 to 23 percent in 50 to 59-year-old women. Why recommend that the 40-year-olds accept an increased risk of death? False-positive results are more common for the younger group, and they require more spending to resolve them. That leads to the smaller “net benefit.”

Many individuals prefer to spend more to buy medical care that lowers their risk of death. In the US, they are still allowed to do so. In European-style health systems, government functionaries may decide saving a 40-year-old life is not worth the extra cost.

gangrene ranked 6th in importance. In 2009 it was ranked 176th. Treatment for tobacco dependence, 186 on the list in 2002, had taken its place. Keep in mind that an estimated 1/2 of all smokers quit on their own and tobacco damage takes decades to develop. Obstructed hernias can kill quickly, people cannot cure themselves, and people die from hernias with obstruction. Bariatric surgery for morbidly obese people with diabetes was ranked 33 in 2009. It was considered a more important treatment than surgery to repair injured internal organs, treatment for appendicitis, treatment for tuberculosis, or treatment for severe to moderate head injuries.⁷³

spending, the other half comes from people who are spending their own money. While it is understandable that government entities might have to limit their health care spending simply because they have reached their budgetary limits, why should limits be placed on the amount and type of health care private individuals purchase with their personal funds? And what is improved if government forces people to enroll in government programs or makes them purchase medical care that they do not want at prices that are higher than they would be without government intervention?

Overwhelming evidence suggests that health care is a normal good. As income goes up, people want to spend more on health care just as they want to spend more on housing, transportation, and education. In two countries with different average incomes but the same population, age structure, disease burden, and health care system, one would expect higher health care spending in the higher income country. In addition to standard medical care, higher income Americans purchase more natural product supplements,

While it is understandable that government entities might have to limit their health care spending simply because they have reached their budgetary limits, why should limits be placed on the amount and type of health care private individuals purchase with their personal funds?

Does the policy keep people from spending their own money on the healthcare they want? Does it reduce the income that people might use to make private purchases?

A bigger problem with forcing US health expenditures to remain under an arbitrary limit is that while US governments do account for roughly half of US health

**Table 5: What Does Government Think Your Life is Worth?
Values of a Statistical Life Used for Policy Analysis,
Millions of 2015 US Dollars**

Australia	\$3.5
Canada	\$5.6
Malaysia	\$1.0
United Kingdom, transport	\$2.4
United States	
- Transportation	\$9.4
- Health and Human Services	\$9.6
- Environmental	\$9.7
OECD	\$1.8-\$5.5
Source: W. Kip Viscusi. June 2018. "Pricing Lives: International Guideposts for Safety," Economic Record, vol. 94, Special Issue, p 1-10.	

chiropractors, naturopaths, and other “complementary” therapies. In 2012, an estimated 60 million Americans paid \$30.2 billion for at least one complementary therapy encounter. Those with family incomes over \$100,000 spent an average of \$518 per person and used more services. Those with family incomes under \$25,000 spent an average of \$314 per person.⁷⁴

As Table 6 shows, middle-class Americans had median after-tax incomes that were 50 percent higher than in the United Kingdom in 2010. They could spend their disposable income on expensive vacations or larger houses. Or they could buy shorter waits for medical treatment, more rapid diagnosis and testing, more convenient care, private or semi-private rooms in most hospitals, individually fitted wheelchairs for the disabled, better cancer treatment, and rapid access to newer drugs with fewer side effects for the treatment of chronic diseases.

How does the proposed reform distort producer incentives?

Many health care reform proposals include rules that reduce costs for some health care purchasers at the expense of others by legislating preferential pricing, access, or subsidies. In addition to causing pricing distortions, those rules often distort the incentives faced by the people who produce medical products and services. Manufacturers introducing a new product

often use discounted introductory pricing or special deals to induce consumers to accept the risk of trying something new. Once the product has established its usefulness, they raise or lower its price to match what customers are willing to pay. Pharmaceutical manufacturers are no different. Physicians want new drugs that perform better for their patients, but trying new drugs comes with significant risk. Whether they use a new drug will depend upon its effects on their patients.

Medicare Part B reimburses physicians for the drugs they administer. Reimbursement is 100 percent of the average sale price (ASP) of the drug over the last 6 months plus a markup of 6 percent for physician administrative costs. As administrative costs do not necessarily increase just because drug prices go up, this reimbursement rule means that physicians may earn more if they prescribe a more expensive drug. And Medicare’s price for administrative cost is relatively low—in 2012 private insurers who based reimbursements on ASP paid average administrative markups of 18 percent.⁷⁵ Thanks to the way Medicare pays for Part B drugs, providers are likely to be relatively price insensitive due to reimbursement for a large part of the drug’s cost, and manufacturers have no reason to lower prices.

Medicare cannot avoid setting a pricing rule for drugs. But, as Patricia Danzon, the Celia Moh Professor of Health

Thanks to the way Medicare pays for Part B drugs, providers are likely to be relatively price insensitive due to reimbursement for a large part of the drug’s cost, and manufacturers have no reason to lower prices.

Table 6: Middle-Class Median After-Tax Household Income, 2010

Italy	Spain	UK	France	Germany	Norway	US
\$35,608	\$36,169	\$40,888	44,129	\$44,901	\$56,960	\$60,844

Source: Rakesh Kochhar. June 5, 2017. Through an American lens, Western Europe’s middle classes appear smaller. Pew Research Center, <https://www.pewresearch.org/fact-tank/2017/06/05/through-an-american-lens-western-europes-middle-classes-appear-smaller/>

Care Management at the University of Pennsylvania's Wharton School points out, the least bad rules may be those that pay "a flexible discount from [average wholesale price] minus a discount percentage that is adjusted periodically." This creates the "strongest incentives for price competition by manufacturers."⁷⁶ The real problem is that Medicare, unlike private comprehensive major medical plans, is three separate programs that silo reimbursements for inpatient costs, outpatient costs, and retail pharmacy costs.

Sometimes governments pass laws that specifically reduce health care expenditures for government programs by raising costs for people who pay for their own health care. The federal 340B provides another case of unintended consequences from federal rules designed to lower federal health care costs. The 340B program requires manufacturers to sell Part B drugs to eligible hospitals at 20 to 50 percent discounts. It was supposed to reduce the cost of caring for Medicaid patients and people who did not pay for the cost of the hospital care they consumed.

In 2015, Dickson *et al.* estimated that the program reduced manufacturer revenues by almost 2 percent and gave the money, an estimated \$6 billion, to hospitals.⁷⁷ This estimate has been criticized as far too low because it compares 340B purchase with all prescription drug purchases. Since ninety percent of 340B drugs are branded drugs and the 340B program is limited to outpatient drugs, a report by the Berkeley Research Group argues that the appropriate market comparison is with the total branded drug market used on an outpatient basis. The study, which was funded by the Pharmaceutical Research and Manufacturers of America, estimates that on this basis the 340B program accounted for almost 8 percent of all branded outpatient drug sales in 2016, up from 5 percent in 2012.⁷⁸

Since 340B program eligibility was liberalized in 2003, almost 50 percent of hospitals have managed to qualify. As hospitals keep the difference between the list reimbursement rate and the discounted price, the discount increases hospital profits. It also artificially lowers their costs for some treatments to a level that specialists in private practice find hard to match. Significant numbers of physicians have left independent practice and joined hospital groups in order to become eligible for the discounts. As a result, the proportion of patients treated in 340B hospitals grew by 5 to 10 percent while the proportion treated in physician offices fell.⁷⁹ As Medicare pays extra for treatments at hospital affiliated clinics due to the Medicare facility fee, the 340B program likely ended up benefiting hospitals at the expense of pharmaceutical companies, while increasing overall Medicare payments for general cancer treatment.

Colorado provider taxes are another example of self-serving government intervention that makes government better off at a cost of distorting incentives for suppliers and increasing health care costs for private payers. Since 2009, people who pay for their own health care have paid a tax for each day they spend in the hospital and the equivalent of a 1.9 percent sales tax on any outpatient treatment. Because it increases the cost of hospital services used by Medicaid patients, the provider taxes increase the amount of federal matching funds the state receives from the federal government. The taxes plus the federal matching funds were used to expand Medicaid eligibility and transfer significant sums from patient payments in private hospitals to hospitals that treat substantial numbers of Medicaid patients.

Although state law prohibits hospitals from reporting provider taxes on their bills, this form of subsidy harms private

Since 2009, people who pay for their own health care have paid a tax for each day they spend in the hospital and the equivalent of a 1.9 percent sales tax on any outpatient treatment.

payers because there are only two ways hospitals that pay more in provider taxes than they receive in grants can raise the money to pay the tax. Either they increase the prices they charge their patients, or they keep their prices the same but reduce their services. A better way to subsidize Medicaid expansion, one that does not artificially raise the cost of private health

care in order to reduce the apparent cost of the Medicaid program, would be to fund Medicaid expansion from general tax revenues.

Part VI—Spot the Comparison Flim-Flams: Higher Expenditures are Not the Same as Higher Costs, and Other Problems with Cross-Border Health Care Cost Comparisons.

In some quarters it is fashionable to recommend that the US adopt the Swiss health care system. Enthusiasts claim that Swiss health care costs less than US health care because Swiss health expenditure is \$8,009 per person while US health expenditure is \$10,224 per person. The lower Swiss expenditure is offered as proof positive that the Swiss are doing something right. But this is true only if four assumptions hold:

1. The Swiss and American populations have the same health needs. This means that age structures, genetic endowment, endemic disease, general geography, and individual behaviors are the same. Otherwise, the health system in the country with less disease burden or less costly geography will have lower expenditure even if the two health systems have the same cost structure.
2. The US and Swiss governments must measure health spending in the same way. The US includes expenditure on research in its national health spending accounts, some other countries do not. Because US health care has long had a

significant private payment component, US spending estimates also include some spending for auto and other liability insurance that pays for some medical bills.

3. The Swiss and US systems perform equally well at diagnosing disease, restoring people to health when possible, and prolonging life and reducing suffering when it is not.
4. The unmeasured costs borne by patients are the same in both countries. This assumption is clearly violated if one country has long wait times for health care access and the other does not.

As no two countries fulfill these assumptions, comparing health spending between countries is a tricky business. The Organisation for Economic Cooperation and Development (OECD) produces the international health spending comparisons that are often cited in US public debate. It has spent years developing comparative measures to facilitate cross-border health system comparisons. OECD efforts to develop a common measure of national spending date back to 2000, when it

Comparing health spending between countries is a tricky business.

Playing Games With Health System Rankings

The Commonwealth Fund has long advocated for government run health care in the United States. It periodically publishes survey results rating health system performance in selected industrialized countries.

The questions the surveys include invariably favor government-run systems. In the 2017 “Mirror, Mirror” survey, there were 6 questions that specifically addressed cash payments for medical care, asking whether patients had problems paying them. Patients in many government run health systems do not care about cash payments because they pay with higher taxes rather than with payments at the time of service.

Though tax supported government-run systems are more likely to have problems with waiting times, there were just 3 questions about waiting time to specialized treatment and they were addressed to doctors.

By design, the US does worse on the 6 cost questions. It does well on the 3 wait time questions, but when the scores are added up and averaged, the US will be below average due to the distribution of measurement questions.

The World Health Organization’s 2000 ranking of international health systems played the same sort of games. If the rich didn’t pay more for health care, countries received a lower ranking. If government paid for more health care, a country received a higher ranking. Finally, WHO measurement choices defined equity in a way that let a country providing lousy care for all rank higher than one that provided great care for most and average care for a few.

Glen Whitman, February 28, 2008. WHO’s Fooling WHO? The World Health Organization’s Problematic Ranking of Health Care Systems. Cato Institute Briefing Papers No. 101. <https://www.cato.org/publications/briefing-paper/whos-fooling-who-world-health-organizations-problematic-ranking-health-care-systems>

first proposed that countries account for their health expenditures using its newly developed System of Health Accounts (SHA).

In 2016, European Union countries began using SHA to estimate their health care spending. Ireland, Sweden, and the United Kingdom saw substantial increases in their estimated health spending even though their national budgeting procedures were unchanged. This means that estimates for preceding years are not comparable, and calculations of annual increases in spending may be unreliable. The British Treasury says that the health accounts in 2014 (published in 2016) and later are not comparable with the Healthcare in the UK series which ran from 1997 to 2013.⁸⁰

In Japan, national health spending estimates did not include spending on long-term care services or services not covered by public health insurance. When Japanese health spending is recast into the SHA accounting system, Japanese health spending was 127.4 percent of its previous total. As the SHA does not include spending for health research and training for health workers, recasting other national spending estimates into the SHA format reduced health spending estimates. Canadian national health spending estimates included training health workers, health research, and social work activities performed in hospitals. SHA estimates do not.⁸¹ Recasting Canadian spending using the SHA produced a 3.3 percent decrease in estimated Canadian health spending. Like the Canadians, US national health spending estimates include the amounts spent on health research, an amount that is subtracted when US health spending is reported by the OECD.

Even though definitions may now be the same, countries using the SHA accounting framework continue to use different methods to estimate the volume

of hospital activities, doctor services, and other health activities that are reported in the Shared Health Accounts format. The quality of surveys, adjustments, and estimates varies from country to country, causing SHA accuracy to vary as well. Estimates of out-of-pocket health care spending tend to be imprecise because they depend on rather weak survey data,⁸² and out-of-pocket spending varies considerably across countries. In Switzerland, out-of-pocket spending approaches 30 percent of total spending. In England and Canada, out-of-pocket spending is roughly 15 percent of spending. In the US it is estimated at just over 10 percent of spending. In countries with high out-of-pocket spending, the inability to measure out-of-pocket spending may create imprecise national spending estimates.

Sometimes the title of sections in the Shared Health Accounts framework mislead US health activists because the title means different things to the OECD than it does to Americans. The SHA section called “Governance, and health system financing and administration” does not measure health system administrative costs as they are understood in the US. One part of the section measures the administration of health financing that is “applicable to insurance schemes.” It covers the cost of insurance company administration, interest earned on reserves, profit, and insurance premium taxes. The other part of the section measures government spending on developing health care regulations, setting and monitoring standards of care, and “strategic governance” of the health care system. No part of the section reports government expenditure on the overhead costs of government run systems. Overhead is distributed to other areas of the System of Health Accounts. This means that OECD data on health system administration and financing

Different Definitions Distort Infant Mortality Rates

In a 2018 Health Affairs article excoriating the US health care system for its poor performance in children’s health, Thakrar *et al.* claimed that “perinatal conditions” and infant deaths at or shortly after birth were responsible for “the most striking disparities between the US and the OECD19” countries.

There is a large academic literature going back to at least 1980 explaining that differences in birth registration practices make infant mortality rates inappropriate for comparing health system performance between countries. Until recently, many European countries counted babies as live births if they met certain gestation, weight, or hours of survival requirements. A common requirement was that babies were live births only if they were born after 28 weeks of gestation.

In 1994, Germany reduced its birthweight limit for counting a baby as a live birth from having a birth weight of 1000 g to one of 500 g. Its perinatal mortality rate increased 20 percent, from 5.5 per 1,000 to 6.6 per 1,000.

The US has long classified any baby who shows any signs of life as a live birth. As very low birth weight babies are more likely to die after birth, the US definition of a live birth automatically increases its infant mortality relative to countries that impose other requirements.

By 1998, Richardus *et al.* had concluded that the “perinatal mortality rate, as it appears in routinely published statistics, cannot be taken at face value and certainly not for the purpose of international comparison.” The OECD now adds a disclaimer to its infant mortality rate data, explaining that “some of the international variation in infant mortality rates is due to variations among countries in registering practices for premature infants.”

In one of the great puzzles of US health policy scholarship, reputable journals like *Health Affairs* continue to publish international health system comparisons based on data known to be unsuitable for that purpose.

costs understate administrative costs for health systems that are more reliant on government financing.⁸³

Do prices really represent costs? In government-run systems, prices reflect administrative decisions, not the value of resources used. This means that estimates of expenditures will not be the same as costs.

Figuring out how to price the volumes of health care recorded in the Shared Health Accounts presents an even bigger problem. When government is the sole supplier of a medical good or service, the prices governments charge reflect administrative decisions, not the value of the resources used. As expenditures are calculated by multiplying prices by the quantity purchased, when prices do not reflect costs, expenditures do not reflect costs either.

The European Union's HealthBASKET project was designed to estimate whether actual costs differed from the reimbursements European governments used to "price" health expenditures. The project developed definitions of 10 care episodes, things like filling a cavity in a tooth or providing a standard hip replacement. It catalogued the resources, time, materials, and so on, used to treat the same hypothetical patient in each of the 10 care episodes in different parts of the 9 participating countries. Then it compared the actual reimbursement to the resource costs for the items used to provide care. Average reimbursements differed between countries. They differed as much or more within countries. In the Netherlands, the "price" for inpatient emergency treatment of a heart attack was €8,722. In Germany, the "price" was €3,114.⁸⁴ For common standardized procedures, things like normal delivery of a baby or colonoscopy, reimbursements and costs matched "fairly well." In the

other cases, the reimbursements were not well aligned with costs. If those "not well aligned" reimbursements are used as prices in calculating national expenditures, national expenditures will not represent actual health care costs.

Many countries do not include capital costs or other payments in their health accounts.

A health system that fails to cover its overhead costs does not allow for the cost of replacing capital used up in providing current health care, and it understates its current health spending. Overhead costs were a major challenge in the HealthBASKET comparisons. Overhead costs include things like administrative costs, software, building depreciation, and the cost of capital along with more mundane things like the cost of sterilizing reusable medical devices, doing the laundry, keeping the lights on, maintaining plumbing, and disposing of waste. In any business, overhead costs must be allocated to the cost of producing products. Different allocation methods can change the "cost" of producing a product. When health providers are publicly owned and funded with global budgets, their budgets may or may not include the overhead costs of providing medical services. In cases when overhead was included in administrative reimbursements, some countries allocated hospital overhead by length of stay, others by the cost of the service.

To make things more confusing, the pricing error introduced by different treatments of capital costs was not a consistent proportion of total cost. In England, overhead was 60 percent of the cost of an emergency appendectomy. In Germany, it was 28 percent. In England, reimbursement for filling a tooth was generally below costs. In Germany it was above costs. In Denmark it was impossible

When government is the sole supplier of a medical good or service, the prices governments charge reflect administrative decisions, not the value of the resources used.

to know what the reimbursement was because dentists were paid out of the annual municipality budget and no reimbursement statistics were available.⁸⁵

Accounting for debt is another problem. In countries with government-run health care, many sub-national entities run continuing deficits. If the political consequences of closing an indebted health entity or letting it fail are too high, national governments have no way to make the entity accountable for overspending its budget. In Britain, the National Health Service deficits are so large that budget increases for 2018/19 will be awarded only to providers that reduce their average patient care costs. This means that even though budgets are slated to increase, estimates of the debt effect suggest that providers will get a budget increase only if they cut patient treatment by about 4 percent.

Despite their best efforts, HealthBASKET researchers believed that they missed some important types of health care spending. In many countries, getting health care requires making payments that are not recorded by national administrative systems. These payments may be required but not recorded as official patient co-payments or they may be “informal” under-the-table out-of-pocket payments, otherwise known as bribes. In Austria, 10.4 percent of patients surveyed in 2013 were offered quicker access to diagnosis or treatment in exchange for a cash payment.⁸⁶

In Britain, drugs purchased by licensed wholesalers at the National Health Service price can be sold abroad, with sellers keeping the difference between the controlled NHS price and the higher prices in other countries. The prices the NHS pays for branded prescription drug prices are among the lowest in Europe. In one study of wholesale prices for oncology prescription drugs, a basket of

drugs that cost an average of £46 per dose in the UK, sold for £78 in Germany and £83 in Ireland.⁸⁷ Pharmacies and hospitals can make significant profits by purchasing prescription drugs at the NHS negotiated price and selling them abroad. In 2010, illicit exports by pharmacies and hospitals were said to have led to shortages of about 40 drugs, including those used to treat cancer, high blood pressure, Parkinson’s and high cholesterol.⁸⁸ By 2019, both legal and gray market exports were causing shortages throughout the British prescription drug supply chain. In October 2019, the UK Department of Health and Social Care responded to the growing drug shortages by making it illegal for licensed wholesalers to export 24 drugs including adrenaline pens for allergies, hepatitis B vaccines, and some contraceptives.⁸⁹

Surprising results from cross-border comparisons of the cost of hospital services

Adjusting for wage and price level differences when comparing health system costs across countries can be just as difficult as pricing overhead. When resources used to produce a nation’s health care are not traded in international markets, using foreign exchange rates to translate from one currency to another can give a false impression of the relative costliness of untraded products. In many cases, the relationship of the prices paid for specific commodities like nurses, drugs, and hospital buildings compared to wage rates are substantially different across countries. Countries in which wages for everyone are low may have low cost nurses relative to countries in which almost everyone earns a higher wage, but even though the nurse wage rate is low by international standards, nursing care for wage earners in the low wage country may be unaffordable.

Pharmacies and hospitals can make significant profits by purchasing prescription drugs at the NHS negotiated price and selling them abroad.

Purchasing power indices help adjust for differences in the relative prices of goods within countries. Although most health expenditure comparisons use exchange rates to translate national expenditures into US dollars, people serious about accurate comparisons of prices in different countries use purchasing power parity indices to get a more accurate picture.

Devised by *The Economist* magazine, the Big Mac Index is a simple purchasing power parity index that provides a rough comparison to price levels in countries around the world. The idea behind the index is that no matter where they are produced, the resources used to produce a Big Mac are substantially the same. This means that when a Big Mac is sold to a customer in one of the 119 countries in which McDonald's has stores, its price reflects the cost of the raw materials, labor, and location needed to produce the same thing in different countries.

In January 2019, a Big Mac cost £3.19 in the UK and \$5.58 in the US. This means that the ratio of local currency cost for the Big Mac basket of goods in the UK/US was 0.57, £3.19/\$5.58. For every dollar Americans spent on Big Macs in the US, the British had to spend 0.57 pounds sterling. If one compared the cost using the foreign exchange rates prevailing at the time, for every dollar Americans spend on Big Macs in the US, the British would have to spend 0.78 pounds sterling. To the extent that the Big Mac index gives an idea of the cost of living, using foreign exchange rates to compare US and UK pricing says that Britain has a higher cost of living, 0.78 pounds sterling per dollar, than the purchasing power parity index of 0.57 pounds sterling per dollar.⁹⁰

Change the Big Mac ingredients to a basket of standard hospital services and it is possible to use the same concept to compare the cost of baskets of hospital

services in various countries. The OECD has defined a basket of standard hospital services. The basket includes common inpatient medical procedures like surgical hip replacement, normal labor and delivery for a single, live-born infant, in-patient treatment for standard pneumonia, an appendectomy, and a coronary artery bypass graft. Researchers collected market prices for each service in each country. When market prices were not available in government run systems, OECD researchers created quasi-prices using administrative databases on reimbursements, adjusting for overhead costs as best they could.

As one would expect, hospital prices were highest in the United States. In 2007, the price level for hospital inpatient services in the US was 164 percent of the average for all the countries compared, nearly 45 percent higher than the price level in Canada (164 compared to 113), and 35 percent higher than the price level in Sweden. But while US hospital services price levels were very high, the overall US GDP price level was 90, the lowest in the group. This means that US hospital prices were high relative to the price of all other goods and services produced in the US economy, but that US goods in general were relatively affordable. As virtually everyone in the US can see that US hospitals do cost a lot relative to other US goods and services, this result suggests that the comparison method yields intuitively reasonable results.

The surprise came when the OECD research team found that although US hospitals were expensive, Americans used less hospital care to treat the procedures in the OECD basket of services. In effect, US hospitals were more expensive, but they made up for their higher costs by being more productive. They get patients diagnosed, fixed-up, and discharged more rapidly than in other countries. Because

The surprise came when the OECD research team found that although US hospitals were expensive, Americans used less hospital care to treat the procedures in the OECD basket of services.

Table 7: Comparative Price Level Indices for Hospital Services, 2014, Average= 100

	Mexico	UK	Germany	Canada	USA	Sweden	Norway	Switzerland
Hospital Service Price Level Index	45	79	92	126	130	132	181	192
Inflation-Adjusted Actual Individual Consumption Index	46	104	112	107	146	102	123	118

Source: Luca Lorenzoni and Francette Koechlin. International Comparisons of Health Prices and Volumes: New Findings.OECD, 2017, .p. 15 <https://www.oecd.org/health/health-systems/International-Comparisons-of-Health-Prices-and-Volumes-New-Findings.pdf> ; OECD.Stat. Volume indices of real expenditure per capita, 2014 PPP Benchmark results.

people in the US used less of their expensive hospital services to perform the common procedures in the OECD basket of comparisons, estimates for the 2014 OECD hospital services purchasing power parity index suggest that the US hospital services needed to treat the ill in the standard basket were less expensive than equivalent services in Sweden, Norway, and Switzerland. They were only slightly more costly than in Canada.

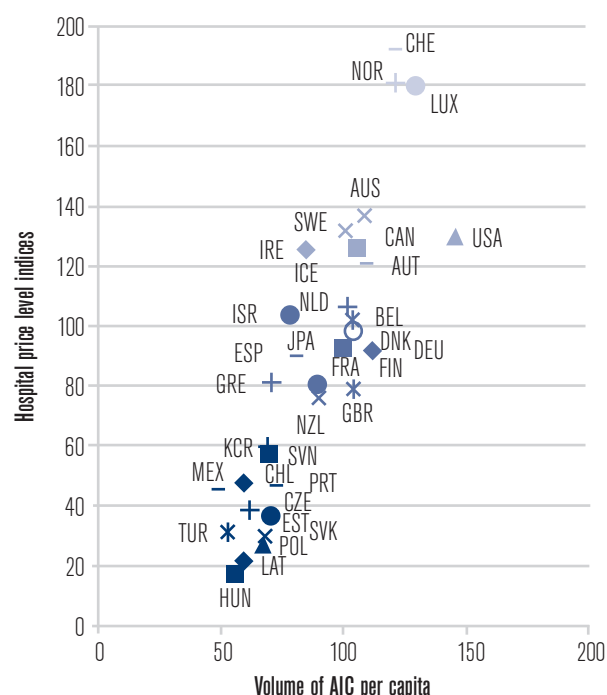
Relative to income, US hospital care is more affordable than in many of the systems US health reformers think the US should adopt.⁹¹ When the OECD compared US hospital service pricing to what US households have left to spend after government takes its portion of their incomes for government uses, US hospital services seemed even more “affordable.” The OECD uses inflation-adjusted per capita Actual Individual Consumption (AIC) to measure average household

material welfare. The AIC attempts to measure all consumer goods and services purchased directly by households as well as services that individuals use that are provided by non-profit institutions and government. Government spending on education is included in the AIC because individuals use it. Government spending on defense, treasury operations and the like are not included because they are not consumed by individuals. The graph shows that as measured by AIC, US households have a higher material standard of living

Relative to income, US hospital care is more affordable than in many of the systems US health reformers think the US should adopt.

Figure 3

OECD = 100



and lower hospital price levels than the Canadian, Swedish, and Swiss systems.

Even more surprising is what happens when US purchasing power price level indices for general health services are compared with those for other countries. Hospital prices are important, but hospital spending is only 30 percent of health expenditure in most OECD countries. To compare the price levels for health care in general, one must also consider relative prices for therapeutic devices, physician

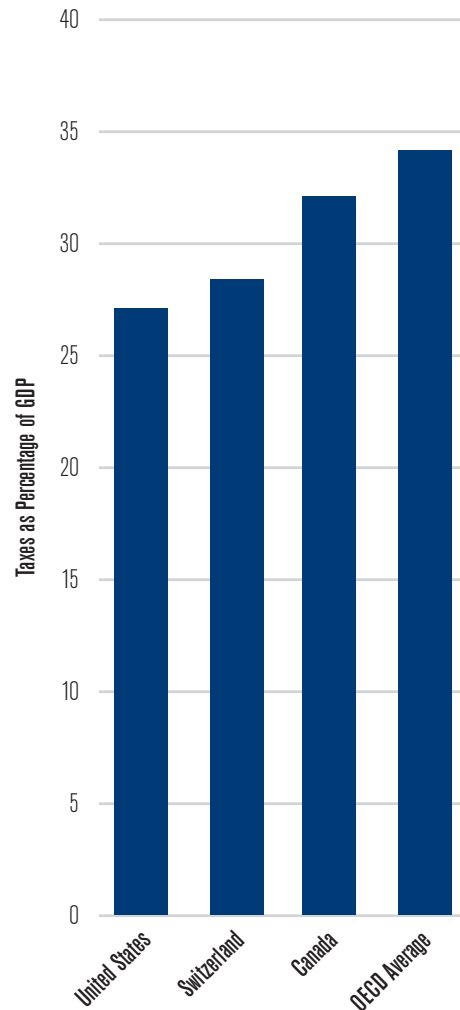
services, pharmaceuticals, the services of auxiliary health professionals, long-term care, and home care.

Producing representative baskets of general health care services is a much harder problem than producing baskets of hospital services, and the OECD has produced only a rough approximation for a basket of general health care services. Its preliminary calculation suggests that the US health care price level index in 2014 was 114, just 14 percent above the OECD average. Britain was at 110, Canada at 127, Sweden at 154, Switzerland at 171, and Norway at 180. These data suggest that the US model of less government control and competition among private and public health systems produces less costly health care than the Swiss and Canadian government run systems.⁹² Work on rankings of prescription drug pricing across national boundaries has produced similar results for US prescription drug costs. It turns out that relative US costliness is sensitive to the choice of price index, the drugs researchers decide to include, the package included in the index, and the handling of currency conversions.⁹³

Surprisingly little academic literature examines whether the relatively high competitiveness in private US health care has made US health care suppliers more efficient producers. Rather than copy the researchers who naively accept OECD spending data at face value, ignore waiting lists, and fail to explicitly consider the quality of care, Feachem *et al.* compared the costs and performance of Britain's National Health Service with those of Northern California Kaiser-Permanente. Like the NHS, Kaiser fully controls the health care of millions of people in an integrated system. It owns its own hospitals, has a fixed budget, and has minimal charges at the time health care is delivered. Feachem *et al.* concluded that

Surprisingly little academic literature examines whether the relatively high competitiveness in private US health care has made US health care suppliers more efficient producers.

Figure 4: Tax-to-GDP Ratios, 2017



Source: Organization for Economic Cooperation and Development, Revenue Statistics 2018 - the United States, Tax-to-GDP ratio. <https://www.oecd.org/unitedstates/revenue-statistics-united-states.pdf>

Kaiser performed better than the NHS on selected quality measures, and that Kaiser physicians were more productive. Its physicians could do more, and they made extensive use of physician extenders. Possibly because Kaiser had many more specialists, its waiting times to see specialists were 1/6th of the NHS and it used fewer hospital services than the NHS. All these attributes helped hold down expenditures. The authors estimated that the NHS could reduce expenditures by 17 percent if it reduced its use of hospital services to Kaiser's level.⁹⁴

Do health expenditure measurements include the costs created by tax financed health care expenditure?

As the previous graph showed, countries with government run health systems have much higher tax to GDP ratios than the United States. High taxes on income and production encourage people to work and produce less, lowering living standards. Because health care is always expensive, countries that use taxes to finance it tend to have lower employment, slower economic growth, and lower standards of living.

Evidence from economics suggests that if taxes go up by \$1 billion, GDP will fall by at least 1.1 billion. For the US, this means that increasing taxes by \$1 billion to spend \$1 billion on government run health care will reduce GDP by more than \$1 billion, making everyone worse off if the reduction is equally shared.⁹⁵ These findings also suggest that the claims regarding government-run health care simply being able to replace private premiums are unfounded. In order to replace \$1 billion in private premiums, government would have to raise \$1 billion in additional taxes and private production would fall by more than the premiums the government is supposed to replace. Similar

results apply at the state level. The largest losses are likely to be experienced by a state that decides to unilaterally provide tax financed health care that is "free" at the point of service. Lower income individuals seeking "free" health care will move in. Businesses and individuals paying the high taxes to provide it will move out.

Examples of deadweight loss

Another drawback of tax funded health systems is that they take money away from productive private sector uses and spend it instead on things highly valued by the politicians and bureaucrats. The two are seldom the same. Other production losses occur when people use resources to avoid or evade high taxes. Economists call the cost of the tax financing the deadweight loss of taxation. It represents the lost value of the activities that were not undertaken.

The Connect for Health Colorado, Colorado's Affordable Care Act health benefits exchange, is an example of a deadweight loss created by channeling money from private to public use. The exchange produces lists of the individual health coverage policies available for subsidy in Colorado. It is staffed by "navigators," people who are supposed to explain the health policies to people shopping for them. They do not work for insurance companies and are not allowed to advise people on which policies might suit them best. By FY 2015, Colorado was spending an estimated \$45 million a year to fund its benefits exchange, an organization of 78 employees trained to explain what coverage plans contained but who could not advise on coverage, provide coverage, or subsidize it.

Before the ACA, similar policy content and pricing information was available from insurers and from websites like eHealthInsurance.com. Health insurance brokers made their livings helping

Because health care is always expensive, countries that use taxes to finance it tend to have lower employment, slower economic growth, and lower standards of living.

Public Deadweight: Colorado Designs Nursing Home with High Staffing Costs

When the Veterans Administration required one Licensed Practical Nurse for each 30 nursing home residents, the private sector immediately realized that units of 30 or 60 beds were the most cost-efficient to staff. But Colorado's State Veterans Nursing Home at Fitzsimons, which began operations in FY 2003, was built with 42 and 48 bed units. State officials defended themselves by noting they had "considered input from the veterans community and worked with an architectural firm in designing the facility."

To meet Veterans Administration requirements, the Fitzsimons facility was required to staff 2 Licensed Practical Nurses for each of its 4 units. This resulted in Licensed Practical Nurse staffing costs that were 33 percent higher than in facilities arranged in 30-bed units, and total nurse staffing costs that were 10 to 15 percent higher.

According to the Office of the State Auditor, the Home's financial management lacked "accurate, timely, and complete financial management information" making it "difficult to assess the facility's ability to reach break-even status and to continue principal and interest payments" on debt the debt issued to build it."

Although SB 98-186 had authorized the construction of the Fitzsimmons Home, it did not appropriate general funds for ongoing operations. The state combined the operations of 5 of the state-operated state and veterans nursing homes, using them to subsidize Fitzsimons' costly operational budget as necessary.

Colorado Office of the State Auditor, October 2, 2003, Performance Audit: Colorado Department of Human Services State and Veterans Nursing Homes.

customers choose the best policy for their circumstances. They earned commissions of 2 to 3 percent of the premiums paid on the policies they sold. Brokers had a strong incentive to intercede with insurers on behalf of clients because they continued earning money if happy customers kept purchasing their policies. Insurers had an incentive to keep brokers happy, informed, and selling policies as long as policyholders made money for them. Compared to experienced brokers, ACA navigators tend to be less knowledgeable about the details of health insurance, minimally conversant with the more subtle differences in insurance plans, and are not allowed to express opinions on what policy might be best for an individual. They also do not advocate for clients who have problems with their insurer.

Deadweight losses also occur when tax financed coverage accommodates private producers' intent on manipulating government rules to their advantage. Like private producers, states routinely act as special interests when they target federal Medicaid funds. They use state taxes to boost their share of federal Medicaid matching funds, harming people who pay taxes in two ways: taxpayers pay additional state taxes on the services they use if they are hospitalized or use outpatient surgery, and they pay federal taxes to provide the federal matching funds for the extra cost that the taxes add to state Medicaid bills. States do not necessarily spend extra Medicaid funds wisely. In one of the more egregious examples, a Colorado school district used Medicaid funds to pay for refrigerator magnets stamped with healthy snack suggestions. Left to themselves, it is unlikely that households spending their own money on health coverage would be willing to pay higher premiums and taxes to get snack magnets from their health insurer.⁹⁶

Thanks to special interests, Medicaid expenditures are much larger than would be needed to simply provide medical care to its clients. In 2018, Finkelstein *et al.* calculated that “the resource cost of providing Medicaid to an additional recipient is only 40% of Medicaid’s total cost; 60% of Medicaid spending is a transfer to providers of uncompensated care for the low-income uninsured.” Estimates of how much Medicaid recipients valued the services they received suggested that “Medicaid recipients would rather give up Medicaid than pay the government’s cost of providing it,” and that from the point of view of people with low incomes, redistributing a dollar to low-income people using Medicaid is less valuable than redistributing a dollar using the Earned Income Tax Credit.⁹⁷

In 1992, health economist Patricia Danzon, now the Celia Moh Professor of Health Care Management at the Wharton School of Business of the University of Pennsylvania, compared the cost of Canada’s government run provincial insurance plans with the cost of private insurance in the United States. She conservatively estimated the overhead of Canadian provincial plans at 0.9 percent of total spending, or 1 percent of benefits payments, while the overhead for US private firms was estimated as 7.6 percent of claims net of premium taxes, return on capital, and investment income. Noting that at the time that the real cost of raising one dollar of US general tax revenue had been estimated to be about \$0.17, Danzon estimated that the deadweight cost of tax financed government run health care was 17 percent of the public insurance overhead.

Even with low estimates of administrative costs for public programs and excess patient time costs, she concluded that “the costs associated with tax-based financing and rationing by other than

price-or information-based methods may be at least as great as the parallel costs of premium collection and claims administration incurred by private insurers.” In summarizing one of her references, she noted that “In Quebec, in the two years immediately after the introduction of universal health insurance, home visits dropped by 63 percent, telephone consultations fell by 41 percent, physician time spent per office visit declined by 16 percent, and office visits rose by 32 percent. Nevertheless, physicians’ relative net income increased over 30 percent in the same period.”⁹⁸

How useful is life expectancy in comparing US health system performance with that of other countries?

As proof that government-run health systems are better, advocates for them often cite the fact that estimated US life expectancy at birth is in the bottom third of estimates for OECD countries. Sometimes they go so far as to claim that the failure of high US spending to produce high US life expectancy demonstrates that all almost all excess US medical spending is wasteful.

Life expectancy at birth measures how long someone born in a particular year can expect to live if population deaths in each age group at the time of his birth remain the same throughout his lifetime. In 2017, life expectancy estimates for the US suggested that a man born in 2017 could expect to live 76.1 years. A woman could expect to live 81.1 years. In other countries, men born in 2017 could expect to live 81.6 years in Switzerland, 79.9 years in Canada, and 78.7 years in Germany. Women could expect to live 87.3 years in Japan, 85.6 years in France, and 84.0 years in Canada.

As proof that government-run health systems are better, advocates for them often cite the fact that estimated US life expectancy at birth is in the bottom third of estimates for OECD countries.

Limiting Hospital Births Increased Baby Death Rate

In the early 2000s, the Dutch health planners assumed that experts could accurately assess a pregnant woman's risk of delivery complications. Planners decided to reduce expenditures by assigning low risk pregnant women to home births with midwives rather than to hospital births under obstetric supervision.

By 2004, the Dutch had one of the highest perinatal mortality rates in Europe.

In 2010, Evers et al. found that the Dutch perinatal death was "significantly higher among low risk pregnancies in midwife supervised primary care than among high risk pregnancies in obstetrician supervised secondary care." Babies born to "low risk" women under midwife supervision who were transferred to hospitals during labor had a more than 3.5-fold higher perinatal death rate than those born to "high risk" women who began labor under obstetric supervision.

Although the absolute risk of problems with a midwife supervised home birth remained relatively small in percentage terms, roughly 2 to 3 deaths per 1,000 babies delivered, the Evers results showed that the Dutch system did not accurately assess the risk of home births.

Source: Evers et al. "Perinatal mortality and severe morbidity in low and high risk term pregnancies in the Netherlands: a prospective cohort study," *BMJ* 2010;341:c5639 <https://www.bmj.com/content/341/bmj.c5639.full/>

Even if medical care could prevent some deaths in every age cohort, different rates of homicide, drug abuse, suicide, engagement in risky sports, and accidents would create different life expectancies in different countries even if their health care systems were exactly the same. A country with superior health care could still have lower life expectancy due to differences in its people's genetic endowments, past smoking levels, family stability, deaths from violent weather, obesity rates, traffic death rates, epidemics of new disease, and the risks associated with the different ways that people earn their livings.

Individual behavior also matters.

Widespread access to cancer screening can improve life expectancy, but it does so only if people volunteer to be screened.⁹⁹

In England, the National Health Service offers free Bowel Cancer Screening for all adults aged 60-74 years old. Though screening clearly reduces deaths from bowel cancer, only 35 percent of eligible people have signed up for it in low income areas. In high income areas, 61 percent of people have had the test.¹⁰⁰

In the US, an estimated 17 percent of the life expectancy gap between African American and white men was erased when the homicide rate declined from 1991 through 2014.¹⁰¹ The US homicide rate for whites 15-24 years old in 2014 was 2.4 per 100,000. It was 38.6 for 15 to 24 year-old African Americans.

Some clues about relative health system performance were provided by the 2014-15 flu season. The influenza vaccine was a poor match for the predominant influenza strain that year, the flu season was a bad one, and in most industrialized countries life expectancy declined because more people over 65 died from influenza and pneumonia than usual.

People over 65 fared better in the US. Its 2014-15 life expectancy declines were

caused by deaths in younger age groups from causes that are generally not affected by health system quality. Ninety-four percent of the life expectancy decline for US men was attributed to behavioral changes that are not affected by medical care, notably an increase in murders and an increase in widespread drug abuse of illicitly manufactured fentanyl.¹⁰² Only a tiny fraction of the US life expectancy decline was caused by deaths from influenza, pneumonia, and other respiratory diseases. Even though US life expectancy declined, the difference in death rates from causes that good medical care can affect among people over 65 suggests that it is possible that the US health care system performed better than the health systems in other countries.

Examined carefully, changes in life expectancy may provide information on how well large scale policy changes have affected health system performance. When the Hospital Readmissions Reduction Program reorganized medical payments under the authority of the Affordable Care Act, the increase in deaths for heart failure patients suggests that at least one of the policy changes embodied in the Affordable Care Act may have reduced the effectiveness of US health care.

In the Netherlands, changes in Dutch life expectancy before a major policy experiment with global budgets suggests that they are bad for people's health. Like most countries, the Netherlands enjoyed mortality rate declines and rising life expectancy after World War II. In the 1980s the Dutch government became concerned about rising expenditures. To slow spending, it put hospitals on fixed global budgets. In the 1990s, budgetary controls were expanded by imposing capacity constraints on specialists. Although mortality rates continued to decline in other countries, Dutch mortality rates began increasing for newborns and

the elderly, two groups that are significant users of medical care.

At the end of the 1990s, the Dutch government abolished global hospital budgets and ended specialist capacity constraints due to complaints about excessive waiting times. The Dutch switched to activity based funding, a variant of fee-for-service payment.¹⁰³ Between 1999 and 2003, Dutch health care expenditures on specialist visits, drug prescriptions, hospital admissions, and surgical procedures all increased, and overall health spending rose by more than 40 percent per person.¹⁰⁴

As Dutch health expenditures increased, so did Dutch life expectancy. Once the Dutch government began providing more health care, deaths from diabetes, heart disease, stroke, and pneumonia fell.¹⁰⁵ From 2000 to 2009, life expectancy increased by 1.8 years for women and 1.5 years for men.¹⁰⁶ Mackenbach *et al.* concluded that around “two-thirds of the increase in life expectancy after 2002 resulted from declines in mortality among those aged 65 years and older.” Higher spending may also have reduced patient suffering. From 2001 to 2005, “the frequency of euthanasia, assisted suicide, and withholding or withdrawing life-prolonging treatment declined, while the frequency of intensified alleviation of symptoms increased.”

While there is no doubt that people want to buy medical care in order to prolong life, they also spend money on health care to improve functioning and reduce suffering. Evaluating how well health care systems perform these functions requires looking at other measures than life expectancy. In 2007, an OECD report examined the prevalence of severe disability among those over 65 years old in 12 countries in an effort to see whether modern health care had reduced

In the Netherlands, changes in Dutch life expectancy before a major policy experiment with global budgets suggests that they are bad for people's health.

disability rates over the last 10 to 20 years. It concluded that only the US, Denmark, Finland, Italy, and the Netherlands had managed to reduce severe disability. In Belgium, Japan, and Sweden, the rate of severe disability increased.¹⁰⁷ The US result is even more impressive when one considers that the US is generally thought to have a higher obesity rate and higher major disease prevalence, both conditions that would lead to higher disability rates.

Preston and Ho evaluated existing evidence on the relationship between life expectancy at birth and the performance of the US health care system. They concluded that

...by standards of OECD countries, the US does well in terms of screening for cancer, survival rates from cancer, survival rates after heart attacks and strokes, and medication of individuals with high levels of blood pressure or cholesterol... we conclude that the low longevity ranking of the United States is not likely to be the result of a poorly functioning health care system.”¹⁰⁸

Does size really matter? Do unexploited economies of scale exist in US health care and how important is geography in health care cost comparisons?

Reformers often claim that government run health systems lower costs because the size and scale of the government purchasing power can provide for larger, more efficient, operations. They also believe that government drives harder bargains with private producers. Government pricing power, the story goes, can force private producers to lower prices, and many reformers in Colorado claim that the state or a group of states could lower drug prices by using the leverage of a large group purchase to get better prices.

Colorado has about 5.7 million people. UnitedHealthCare’s December 2017 health plan enrollment was about 50 million people, Anthem’s enrollment 40 million, Aetna’s membership was 22 million, and Cigna’s enrollment was 15.9 million.¹⁰⁹ All of these insurers have a strong incentive to negotiate lower costs because their stockholders keep the difference between premium payments and the cost of providing health care for their members. If advocates are correct and more members means lower costs, then it is hard to see how a government run system representing 5.7 million lives provides better leverage than a health insurer covering 50 million ones.

Claims that larger pools of insured reduce prices because they spread the risk must also be treated with caution. Premiums depend on the average health care costs of the people enrolled in an insurance pool. The high premiums caused by the Affordable Care Act have caused millions of people to drop their individual major medical coverage and seek other healthcare financing arrangements like medical sharing plans. The people dropping coverage are likely to have lower medical costs than those willing to pay high premiums to keep their coverage. This means that while the ACA requirement that insurers use a whole state risk pool may have created a risk pool with more people in it, it may not have created a risk pool with lower per person medical costs than the smaller pre-ACA risk pools each insurer used to determine premiums for medically underwritten individual policies.

It is well known, for example, that when the Affordable Care Act was passed, the State of Colorado added almost 14,000 people with much higher than average medical costs to Colorado’s individual insurance market at the end of 2013 when it closed the CoverColorado plan

The high premiums caused by the Affordable Care Act have caused millions of people to drop their individual major medical coverage and seek other health-care financing arrangements like medical sharing plans.

for people who were uninsurable due to pre-existing conditions. To get a rough estimate of how much individual Obamacare premiums would have had to rise just to cover the costs of the new arrivals, consider that smaller number of CoverColorado enrollees required \$77 million in subsidies to cover their health care costs in 2011.¹¹⁰ In 2015, America's Health Insurance Plans (AHIP), a trade association, reported that Colorado had slightly more than 316,000 people covered by individual health insurance. Everyone in the 2015 pool would have had to pay an additional \$250 in premiums just to cover an additional \$77 million the State of Colorado saved by dumping the costs of CoverColorado onto people purchasing individual health insurance rather than onto taxpayers in general.

The claim that large health care systems will lower costs by spreading administrative costs and consolidating purchasing power should also be treated with caution. For hospital systems, existing data suggest that while membership in a hospital system may lead to more pricing power and larger revenues, it does not necessarily reduce production costs. There is some evidence that smaller hospital systems have lower production costs than hospitals in larger systems, and that very large and very small hospitals have higher production costs.¹¹¹ When patient outcomes and organizational factors are added to the mix, preliminary results suggest that, as one might expect given the incentives, for-profit and teaching hospitals are more efficient, especially when they are located in more competitive hospital markets.¹¹²

Finally, geography and population size must be kept in mind when comparing national health system costs. The size of the United States, its heterogeneous population, and its geography make its health needs quite different than many

of the countries analysts compare its system to. In some quarters, Switzerland's health system is said to be a model for the US. Switzerland has a population of 8.6 million, about as many people as the Chicago metropolitan area, and they live in a land area about one and a half times the size of Chicago. A better comparison might be Switzerland to Virginia, which has about as many people and only 2.5 times more the land area, or Switzerland to Massachusetts, with 6.9 million people and a little less than half the land area.

Because underlying health varies by region, variations in pricing and expenditure often reflect geographic variation in the prevalence and severity of chronic diseases. Retired people tend to spend more on health care than younger people. If more retired people move to Florida or Texas, one would expect health spending in Florida and Texas to increase relative to health care spending in the states the retirees left. If an area's industries grow, attract more people, and create new fortunes, health spending may rise as higher wages allow people to pay for more expensive drugs with fewer side effects, more plastic surgery, or more imaging to speed diagnosis. Though this kind of spending makes people better off, it likely will not affect mortality, life expectancy, or other commonly cited measures of group health. Also, supporters of government run health care will shortly follow with claims that the extra spending is waste because there are no measures to show how much people benefit from better services.

Recent work suggests that the proportion of the variation in regional spending explained by variations in people's health is much larger than previously believed, leaving less room for attributing spending variation to inefficiency in physician and patient behavior. Reschovsky *et al.* looked at claims for 1.6 million Medicare beneficiaries in 60 communities. They

The claim that large health care systems will lower costs by spreading administrative costs and consolidating purchasing power should also be treated with caution.

found that population health “likely explains more than 75% to 85% of cost variations across fixed sets of areas.”¹¹³ As common sense might suggest, they found “a strikingly consistent pattern of higher acute and chronic illness burden in high-cost areas, even for conditions that appear insensitive to diagnostic and coding practices.”

Population density also matters. Modern medicine needs a lot of specialized equipment to work its miracles, highly specialized people to run it, and people with extensive experience to decide what is likely to help a patient with a specific problem. In the geographically compact Netherlands, where everyone living on the mainland is within 25 minutes of a hospital,¹¹⁴ the same processes used to decide on the purchases and locations of Dutch hospitals, testing equipment, doctors, nurses, and transportation facilities is unlikely to produce desirable outcomes in Maine or Mississippi where more people live in rural areas and distances are greater. Spending more on facilities and staffing for remote emergency care to stabilize and transport patients is likely to be more appealing to someone living at the bottom of the Grand Canyon in Supai, Arizona, than it is to a person who lives next door to a Level 1 trauma center in Chicago.

Because the US system still has significant private spending, the supply of health care can respond to changes in local patient demand in ways that do not occur when government completely controls the size and location of health care facilities. Like most industrialized countries, the US has a shortage of physicians in rural areas. States and the federal government spend billions designing workforce plans, developing incentives to put physicians in rural areas, and supporting rural hospitals. It is possible that these efforts could be eliminated, reducing health care

expenditures, if government health plans made more effort to let markets determine their reimbursements.

As former FDA Commissioner Scott Gottlieb explained in late 2002:

Centralized efforts aimed at computing the optimal number of new physicians to train have always become politicized, pitting academic doctors who want more inexpensive labor, obedient underlings, and rich government subsidies against private-practice physicians who want fewer doctors hanging out new shingles in their neighborhood. It is likely that more government planning or a new agency would become similarly politicized, with warring camps privately exercising their own incentives. Nor would such a centralized policy prescription guarantee that new doctors would end up in communities where they are most needed.

The free market, even gummed up by a high regulated health care system, eventually works. When there was a relative glut of new anesthesiologists about ten years ago, private medical practices responded by dropping starting salaries. Medical students responded by refusing to go into anesthesiology residency programs, worried about their post-training economic future. Faced with fewer applicants, the programs themselves responded by cutting training slots, which has slowly resulted in a shortage of new anesthesiologists.

Starting pay for graduating residents in anesthesiology is now soaring. Training programs have

Because the US system still has significant private spending, the supply of health care can respond to changes in local patient demand in ways that do not occur when government completely controls the size and location of health care facilities.

again become competitive as top medical students clamor for entry. It is revealing to see how quickly graduating medical students respond to markets for various medical specialties when they are choosing their residency training. This is proof anew that the best policies for finding the optimal number of new residents are plans printed on green paper, freely exchanged between self-interested parties.¹¹⁵

preferences and technology. If an indicator of “good” policy puts heavy weight on measures that save people’s lives and ameliorates their suffering, then good health policy must also leave room for health system architecture to undergo rapid changes as technology, incomes, and patient preferences change. If existing evidence shows anything, it is that government-run systems are far less flexible than those in which government limits its role to subsidizing private payers.

Even if everyone knew that there was one ideal health system, its structure would have to change along with patient

Part VII—As International Comparisons are Difficult and often Uninformative, Why Not Compare the Strengths and Weaknesses of the Different US Health Care Systems?

The following section discusses incentive structures and outcomes for several of the major health care systems operating in the US. Although analysts often carelessly refer to “the US health care system,” health care in the US is provided by multiple health care systems operating simultaneously. Some of the systems, the Veterans Administration, Medicaid, and Medicare are the largest, are tax funded systems operated by governments. Others are dependent on private payments. People may or may not be voluntarily enrolled in US systems and they have different levels of control over the kind of medical care they are offered and how they will pay for it.

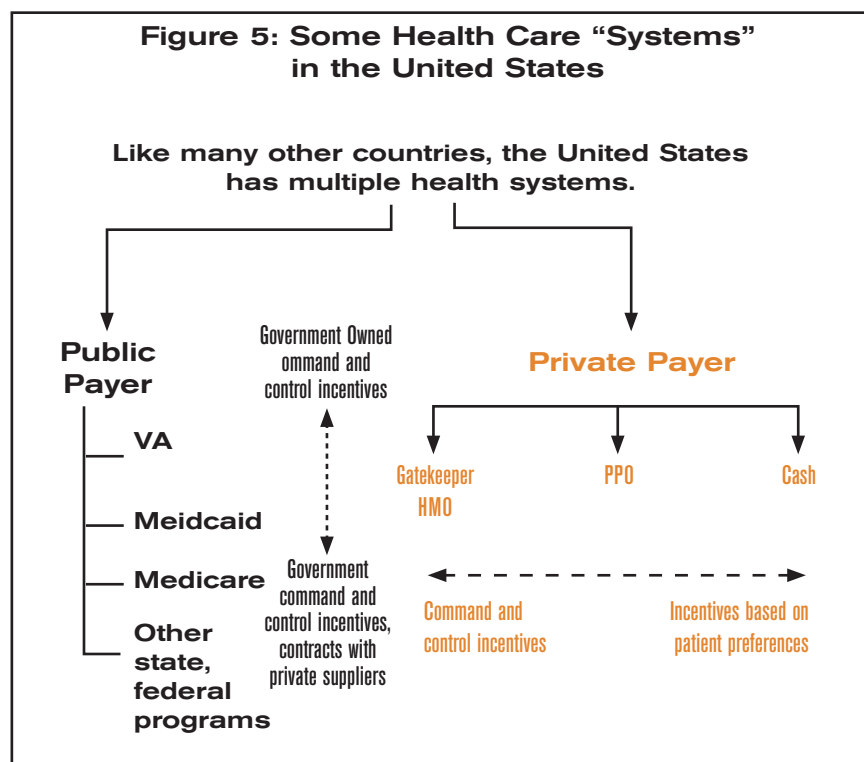
Ownership structures, payment structures, funding, and outcomes vary across the US health systems, and it is much easier to determine how the incentive structure and

likely outcomes of a proposed health care reform compare to the incentive structures and outcomes of an existing US system than it is to compare a proposed reform to health systems in other countries.

Medical care has always and everywhere been expensive. In the United States, health coverage plans for the general population date back to the fraternal society plans offered by private groups in the 1800s. Government run health care began in 1789 when the US Congress, imitating the British, funded the Marine Hospital Service by taxing American seamen 20 cents a month.

As major medical coverage began to grow after World War II, medical expenditure grew along with it. In 1954, Section 106 of the Internal Revenue Code made all employer contributions to all accident or

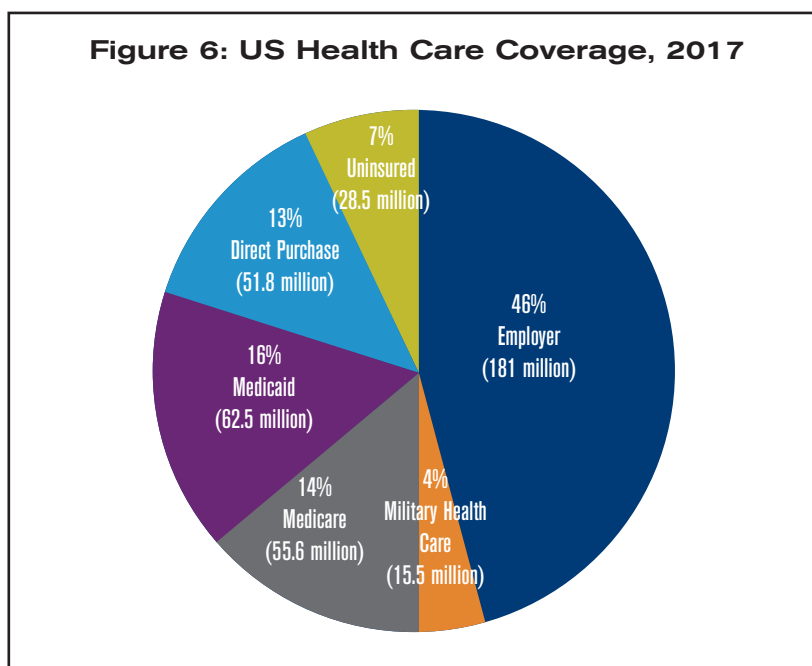
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The tax advantage given to employer purchased health coverage made it less expensive to purchase coverage with pre-tax dollars through an employer than with after-tax dollars as an individual.

health plans tax-exempt. Under Section 105, benefits received under an employer’s accident or health plan generally are not included in the employee’s income. While plans purchased by individuals were purchased with after tax dollars, plans purchased through an employer were purchased with pre-tax dollars.

The tax advantage given to employer purchased health coverage made it less expensive to purchase coverage with pre-tax dollars through an employer than with after-tax dollars as an individual. Employers began offering coverage as a benefit and more coverage began to be purchased through employer sponsored plans. Plans offered by hospitals were also



recipients of special tax treatment during the Great Depression, and their plans dominated the employer coverage market. In short, most Americans purchase health coverage through their employer (but buy their own homeowners, auto, and life coverage) because 1950s tax policy favored employers and employees over people who worked for themselves.

Although households pay for every bit of health care in the United States via taxes, insurance premiums, lost wages, and cash, the money is routed through a mix of private and public systems that both facilitate and control patient and physician choices. The people who control the parts of each system face different incentives. The incentives they face change the kinds of results they focus on, operating costs, the treatment provided, and the difficulty patients have in accessing the treatments they want.

Problems arise when people rely on wishful thinking in evaluating how health reforms will operate. Reformers often say they believe that their reform proposal will produce a certain set of results even though their proposal stipulates organizational and financial forms that have never produced such results in the real world. The similarities between the structures and the outcomes and problems of the British NHS and the US Veterans Administration are instructive. They suggest that if the Veterans Administration or the British National Health Service continue to be government owned monopoly health systems using bureaucratically controlled global budgets to allocate health care, it is futile to promise that either one of them will stop trying to hide their waiting lists, update their capital stock, or have more productive staff. Their very structures create sets of incentives that militate against these changes. Changing the outcomes requires changing their structures.

The Veterans Administration—the NHS of the US. Tax financed, government owned, known for delay, expense, and understaffing

Operating 1,376 medical facilities in 2017, the Veterans Administration (VA) is one of the largest health care systems in America. Veterans who wish the VA to pay for their health care must use Veterans Health System facilities and accept the treatments the VA provides. How much people pay and how quickly they are seen depends on whether their problem is related to their military service, their disability rating, their income, whether they qualify for Medicaid, and any other military benefits they may receive. It also depends on where they live. Some VA facilities have shorter waits than others.

As a federally owned and operated system, the VA does not have to abide by state law. It owns its facilities, sets its own treatment standards, hires its own staff, and determines its own pay and licensing standards. Veterans injured by the VA must first file injury claims with a VA administrative system and are typically denied access to the courts until the VA investigates their claim, a long process that sometimes places legitimate claims outside of statutes of limitations. Like the British National Health Service, the VA operates under a global budget funded by general tax revenues. The VA has problems that mimic those of the National Health Service because, like the NHS, it is a politically controlled monopoly health care system.

Like the people in Britain who pay cash for care outside of the National Health Service, US veterans who are eligible for VA health care often avoid it. Veterans Administration data show that 36 percent of disabled service-connected veterans choose not to use VA health care even

The similarities between the structures and the outcomes and problems of the British NHS and the US Veterans Administration are instructive.

though they use large amounts of medical care and they could get free care from the VA.¹¹⁶ One reason is that people using the VA endure long waits for care, even when it is well known that long waits for treatment of a condition are associated with medical harm. Substantial evidence suggests that people with hip fractures have a lower risk of death, pneumonia, and pressure sores if they receive surgery within 24 hours. When veterans admitted to non-VA hospitals for hip fracture had a median time to surgery of 1 day, veterans admitted to a VA hospital for hip fracture had a median time to surgery of 3 days.¹¹⁷

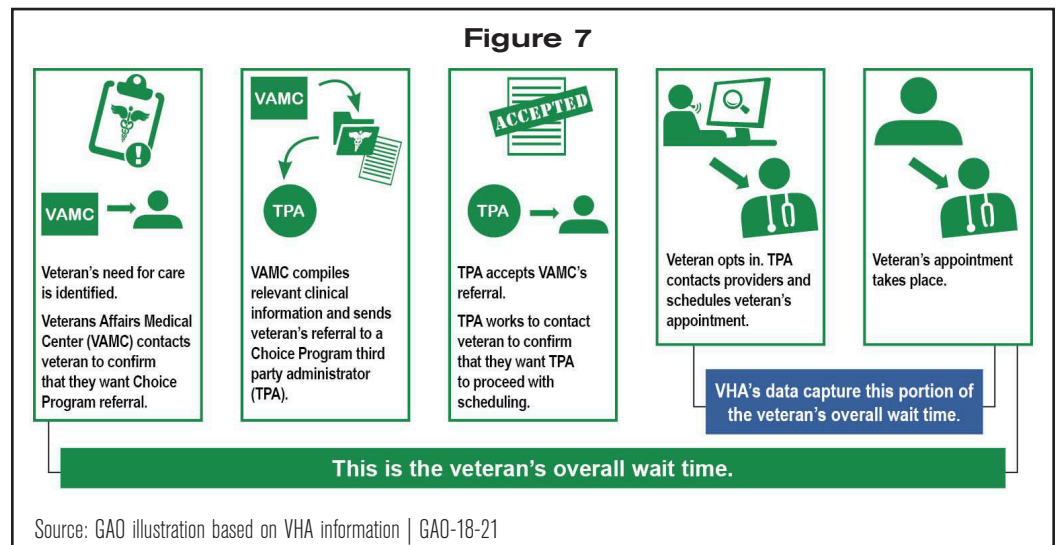
The Veterans Administration, like the NHS, has had recurrent health care scandals and games the system that is supposed to show how long its patients wait for care. Recent scandals include poorly trained surgeons,¹¹⁸ inappropriately denied claims, and cancellation of over 80 surgeries due to phorid flies in an LA operating room. When a 2014 investigation discovered that 120,000 patients never received care due to long waiting lists and that 35 people had died waiting, Congress passed a law to create a 30 day deadline for certain kinds of treatment. Once a patient had waited that long, the VA was required to allow patients to look to the private sector

for care. The program was called the Veterans Choice Program. It broke the VA's monopoly of veterans' health care by allowing veterans to seek out and receive private care under certain conditions, and it required the VA to pay for it.

Being required to pay for outside care was not popular with the VA, and though Congress can pass a law, the VA has many ways to evade complying with it. As was the case when the English National Health Service tried its "targets and terror" approach, VA administrators found ways to game the Veterans Choice requirements. They developed processes making it difficult to get into the Veteran's Choice program and to delay getting care even if one was accepted.

After veterans requested Choice program enrollment, the VA required that they be recontacted to confirm their choice. The VA took its time with the recontacts, waiting for 6 to 53 days to make them. Providing a classic example of what happens to clinical performance measures when they are made into performance targets, VA staff often changed the clinically entered treatment dates that were used to measure timeliness of care. In a manual review of 196 Choice program requests from early 2016, the

The Veterans Administration, like the NHS, has had recurrent health care scandals and games the system that is supposed to show how long its patients wait for care.



GAO reported that Veterans Affairs Medical Center staff manually altered the clinically indicated dates on referrals for about 23 percent of the 196 cases it reviewed. Data on the timeliness of urgent care also became unreliable as staff altered clinical records to upgrade patients from routine care authorizations to urgent care in order to administratively expedite appointment scheduling. Once a patient confirmed he wanted the choice of receiving private sector care, the Veterans Affairs Medical Centers could take unlimited time to forward his medical records and referrals to doctors outside the VA system.¹¹⁹

In one case, a veteran eligible for the Choice Program because he lived far from a VA facility asked the VA for an appointment with a urologist. “More than a month later,” the VA’s third party administrator for the Choice Program contacted a VA medical center for a referral. The medical center responded that no referral was needed because long distance automatically qualified someone for the Choice Program. Four days later, the VA scheduled the veteran’s appointment—with a neurologist rather than a urologist.

In another case a veteran was referred to the Choice Program for treatment of a growth on his lung because there was an unacceptable wait for care at his VA medical center. The medical center contacted the third party administrator 4 times. The third party administrator contacted five Choice Program providers. It could not get an appointment with a thoracic surgeon. The veteran scheduled his own appointment with a thoracic surgeon—for 3 weeks after the medical center first sent his referral to the third-party administrator. Thanks to VA resistance to change, the Government Accountability Office’s June 2018 report concluded that the Choice Program is such

a mess that no one can figure out whether it is working.

Part of the reason patients wait is that the VA, like the NHS, has continuing problems with inadequate staffing. Pew reports that the VA has a “time-consuming hiring process and the pay is lower than in the private sector...There isn’t sufficient support, [and] many VHA doctors say they are frustrated by having to do more paperwork and even clean offices.”¹²⁰ In 2018, an estimated 12 percent of Veteran’s Health Administration positions were vacant. In Denver, a 2017 shortage of anesthesiologists forced the Denver VA hospital to cancel surgeries.¹²¹ The staff that the VA does have is often inadequately supervised. According to 2017 reports from the Government Accountability Office, the VA hires contract physicians and physician trainees, but has no idea how many of them work for it. As a result, its records of clinical workloads are inaccurate, as are its productivity measurements.¹²² In 2017, the VA decided that the physician shortage should be addressed by allowing nurse practitioners to practice without physician oversight.

Because the VA is a government agency, funding will continue no matter how badly it performs and there is little incentive for anyone to do the hard work of controlling costs on a continuous basis. Almost all new VA projects have cost overruns. A recent example is the \$1 billion cost overrun on the Veterans Administration’s new 148 bed hospital in Aurora, Colorado. Initially developed as a \$328 million project, it was almost 3 years late by the time it opened in August 2018, and it had cost more than \$2 billion dollars to construct and “activate.”^{123,124} In contrast, Sutter Health, a private entity with strong incentives to control costs, opened a new 274-bed earthquake hardened hospital in San Francisco in 2019. Construction began in

Thanks to VA resistance to change, the Government Accountability Office’s June 2018 report concluded that the Choice Program is such a mess that no one can figure out whether it is working.

2014. The hospital opened on time and under budget because everyone on the project had incentives to complete their jobs as promised.

When all costs are considered, government run-monopoly health systems make people wait, are slow to innovate, and waste significant resources. A major reason for their inefficiency is that patients have no control over the money spent on their behalf. Patients cannot penalize poor performance by taking their payments elsewhere, or reward good performance by providing spending more money at facilities that meet their needs. The people working in the system cannot be rewarded for exceptional performance or penalized if their performance is below average. When the whole system performs poorly, those responsible simply claim that underfunding is the problem and that no improvement is possible without a bigger budget.

Medicare—in debt, insolvent, and paying providers less than their cost

Medicare is a federal government program created in 1965. Originally designed to cover people eligible for Old Age and Survivors Insurance and Railroad Retirement once they reached age 65, it was expanded in 1972 to cover people with long-term disabilities and end-stage renal disease. It now covers 60.8 million Americans and most Medicare beneficiaries have no other coverage choice. In 2013, Medicare payments were 46 percent of all hospital payments.¹²⁵

Medicare substituted tax-funded spending for private spending. Finkelstein and McKnight estimated that at the time it was first passed, an estimated 46 percent of the elderly had no hospital insurance. People paid for care in their old age out of earnings or savings, and average per

capita medical spending by the elderly in 1963 was \$844, more than 10 percent of income and the equivalent of about \$7,100 in 2019 dollars.¹²⁶ In Medicare's first 5 years, the 25 percent of elderly people who had the highest out-of-pocket medical expenses had their out-of-pocket spending reduced by 40 percent. As out-of-pocket spending fell, total medical spending rose by an estimated 28 percent. Though the additional Medicare spending had no discernable effect on mortality during Medicare's first 5 or 10 years, this does not mean that it was necessarily wasted. The higher health care expenditure may have reduced suffering or improved individual functioning. It is also possible that the increased spending induced technological change that reduced elderly mortality over time.¹²⁷

Unlike the VA, Medicare does not hire clinical staff or own health care facilities. It instead pays private providers who meet its standards a set reimbursement in exchange for providing medical services to its patients. Medicare determines what it will cover, how much it will pay for each procedure, and the standards providers must meet in order to participate. Medicare beneficiaries may use any provider enrolled in the Medicare program. The ability to police bad behavior is one of the benefits of having a government entity certify private plans rather than operating its own plans. Medicare does decertify hospitals offering lousy enough care if they ignore its warnings or fail to try to work with it to improve. Medicare is still subject to political pressure, and decertification becomes a more difficult decision if there are no other facilities available to care for Medicare patients.

At the time Medicare was passed, most advanced medical care was delivered in hospitals. Its designers, like the designers of the public coverage programs in

When all costs are considered, government run-monopoly health systems make people wait, are slow to innovate, and waste significant resources.

Canada and Switzerland, focused on covering inpatient costs, and over 90 percent of Americans are automatically enrolled in Medicare's "free" Part A Hospital Coverage when they reach 65. As the competitive US private market for health care coverage evolved to cover outpatient care and prescription drugs, Medicare's Part A coverage was increasingly out of date and other optional programs were added to it. People covered by Medicare may now choose to purchase additional coverage under Part B for outpatient care by physicians, and under Part D for retail prescription drugs. Because Medicare coverage differs from today's standard commercial health coverage, many people enrolled in Medicare purchase a private policy that fills holes in Medicare coverage. Parts A, B, and D operate on a fee-for-service basis, and enrollment in Parts A, B, and D is commonly referred to as enrollment in traditional Medicare.

Under Part C, the Medicare Advantage program, Medicare beneficiaries can elect to select a Medicare approved private managed care organization that will provide them with all Parts A and B benefits. Medicare pays the private organization a risk-adjusted flat fee when a Medicare patient enrolls, and he then receives his health care from that organization. In many cases, Medicare Advantage plans offer additional benefits like Part D coverage, routine dental care, over the counter medications, or adult day-care services. About a third of Medicare beneficiaries enrolled in Medicare Advantage plans in 2018. Roughly 40 percent of Medicare Advantage enrollees were in health maintenance plans that controlled patient choice using methods such as requiring pre-approval for seeing specialists or limiting patients to receiving care from restrictive provider networks.

Medicare, Innovation, Expenditures, and Costs

New drugs requiring intravenous administration have been developed to treat everything from infections to cancer and chronic diseases. By 2008, private insurers generally covered cost of administering the drugs at home. Even with coverage for supplies and services, home infusion cost less than hospitalized infusion. Outcomes were good, and patients liked being at home.

Medicare would not pay for home infusion. Medicare's reason, according to a Medicare official quoted in a 2008 Wall Street Journal article, was "that the government hasn't yet prepared cost estimates of the pending legislation" and that "the federal program is juggling many other priorities at present."

A Medicare patient without coverage for home infusions who became a hospital inpatient for two months at \$2,000 a day had a different point of view. "It just seemed like such a waste of money and time," he said.

In 2008, a five-week supply of vancomycin through a Medicare Part D plan cost \$100 but Medicare would not cover the other costs of home infusion. They included \$9,900 for pharmacy services, pumps, other equipment, and supplies, along with \$1,400 for 10 nursing visits. Some Medicare supplements did cover at-home infusion, but most Medicare patients choose to check into hospitals or nursing homes so that Part A covered the cost of the treatment.

Unlike the private insurers who are rewarded if a company profits by improving patient care and lowering costs, Medicare officials neither benefit nor lose if they are slow to cover innovations that save money and help patients. A study commissioned by an industry group hoping to pass legislation requiring Medicare coverage of in-home infusion services estimated it would save taxpayers almost \$6 billion over 10 years. A MedPAC study argued that Medicare coverage would increase Medicare expenditures.

By the time Congress got around to updating Medicare coverage in the 21st Century Cures Act at the end of 2018, even some private Medicare Advantage plans covered in-home infusions. If all goes well, Medicare will finally cover them in 2021.

Laura Landro, "As Home IVs Grow, Medicare Patients Miss Out," The Wall Street Journal, October 15, 2008, U.S. Print Edition, online version, <https://www.wsj.com/articles/SB122402901765934551>. Earl L. Carter, "Medicare Policy Is Failing Home Infusion Therapy Patients," The Hill, October 3, 2018, online edition, <https://thehill.com/blogs/congress-blog/healthcare/409542-medicare-policy-is-failing-home-infusion-therapy-patients>; Repot to the Congress: Medicare and the Health Care Delivery System (Medicare Payment Advisory Commission, June 2012), chap. 6, http://www.medpac.gov/docs/default-source/reports/jun12_entirereport.pdf.

In recognition of Medicare's shortcomings as a health insurance plan, almost 90 percent of beneficiaries covered by Medicare fee-for-service plans have some form of additional coverage through employer-sponsored retiree plans, Medicaid, or privately purchased MediGap plans.

Medicare's structure makes it difficult to determine annual financial liability in the event of serious illness. Unlike private insurance, Part A's hospital insurance is based on benefit periods rather than calendar years. Benefit periods are defined as beginning the day someone is admitted to the hospital after he has lived 60 days without any hospital care, something only a bureaucracy would think of keeping track of. Each benefit period has a \$1,364 deductible. Someone unfortunate enough to spend 60 days in the hospital will be charged the deductible plus \$341 a day each day until he reaches day 91. Then the cost becomes \$682 a day for 60 additional days over one's lifetime. Once that lifetime reserve ends, Medicare coverage ceases. In effect, the sicker someone is the more Medicare increases financial stress. Even if someone never reaches the Medicare maximum stay, the multiple deductibles make it hard to calculate one's potential financial liability if one has multiple hospital stays in a given year.

Premiums for the optional purchase of Part B coverage are means tested, range from \$135.50 to \$460.50 a month, and are based on an individual's previous year's income. People who choose not to purchase Part B are responsible for all physician charges, durable medical equipment, outpatient mental health, drugs that are not self-administered, and ambulance services. While the Part B deductible is relatively low at \$185, its copays are not. They are 20 percent of the Medicare reimbursement and there is no out-of-pocket limit on the 20 percent share. Like Part A, Part B imposes higher out-of-pocket costs on the sickest patients requiring the most expensive treatments. Unlike private plans, people enrolled in Medicare have no ability to choose plans offering different levels of financial protection. In recognition of Medicare's shortcomings as a health insurance plan, almost 90 percent of beneficiaries

covered by Medicare fee-for-service plans have some form of additional coverage through employer-sponsored retiree plans, Medicaid, or privately purchased MediGap plans.¹²⁸

Part D, which was added to Medicare in 2004, does a somewhat better job of providing predictable out-of-pocket expenditures though the financial protection it offers is still complicated and, unlike pre-Affordable Care Act coverage, does not offer plans with an upper limit on out-of-pocket costs. In 2020, Part D beneficiaries must pay an initial deductible of \$435. After that, they are responsible for 25 percent of drug costs up to \$9,719 per year and 5% of total drug costs thereafter. Part D coverage is offered by private drug plans meeting Medicare requirements. Premiums vary with the plan, ranging from \$12.18 to \$191.40, and are means tested. In 2020, people with higher incomes will pay premium surcharges of up to \$76.40 a month.

Traditional Medicare's structure makes it difficult to predict household financial liability in the event someone needs expensive health care. It also makes it difficult to limit household financial liability, one of the primary reasons for purchasing health care coverage. Medicare Advantage plans generally offer more certainty about out-of-pocket costs. It is not surprising that private plans competing for Medicare beneficiary enrollment emphasize plans that create financial certainty for people with limited cash flows by offering an array of health care services with no out-of-pocket payments for deductibles or copayments. Or that they attract a disproportionate share of lower income retirees.

Although payments to Medicare Advantage companies are increased if a Medicare beneficiary is in poorer health, plans still receive a specific annual budget

for each person who enrolls. As we have seen, health care organizations facing the incentives created by payment of an annual per patient flat fee have an incentive to avoid high cost patients and skimp on their care. Existing evidence suggests that Medicare Advantage plans respond to incentives as expected. They attract healthier Medicare members, tend to guide patients to lower quality facilities, and limit expensive care. People who need expensive care disenroll from them at higher rates.¹²⁹ Plan enrollment responds to increases in reimbursement. When a floor was set for Medicare Advantage reimbursements in metropolitan areas with low fee-for-service enrollment, a 10.5 percent increase in reimbursement caused a 13 percent point increase in Medicare Advantage enrollment. In areas with more competition, enrollees enjoyed more generous coverage.¹³⁰

Though traditional Medicare does not yet explicitly ration care, it can affect the service mix private providers offer its beneficiaries by changing reimbursement levels. If reimbursements are too low, providers will reduce the amount of care they are willing to provide to Medicare patients. It is important to remember that Medicare reimbursements are not prices. They are administratively determined by Medicare, and are based on its notions of cost. Recent data suggest that there is surprisingly little correlation between Medicare reimbursements and the market-based payments made by private insurers. There is also little correlation between Medicare spending per beneficiary and private spending per insured. In Grand Junction, Colorado, Medicare spends relatively little per beneficiary while private insurers' payments for their insureds put them in the 90th percentile of the US spending distribution.¹³¹ Grand Junction is in an isolated location. It is possible that it attracts relatively healthy retirees and that its hospital uses its market

power to charge private insurers very high rates.

Like many government-run health programs, Medicare pays for the variable costs of staffing and supplies but does a poor job covering capital and other fixed costs. In 2015, the Colorado Hospital Association estimated that Medicare paid for 72 percent of the hospital costs it generated, Colorado Medicaid paid for 75 percent of its hospital costs, and patients with private insurance paid 158 percent of their hospital costs. Self-pay patients and those in the Colorado Indigent Care Program paid 111 percent of their hospital costs.

Though the Colorado Hospital Association obviously has an incentive to paint a dire picture in order to increase reimbursement rates, Colorado's low payments are not unique. In 2016, the Medicare Payment Advisory Commission estimated that Medicare payment rates were just 8 percent higher than the variable costs of treatment.¹³² In 2017, it found that US hospitals lost 9.9 percent on Medicare payments. Losses may be higher in some markets and lower in others. Robinson *et al.* found that in some markets some hospitals fail to even recoup the variable costs they incur in treating Medicare patients.¹³³

In one sample of average Medicare payments for hospital hip replacements, the health care transaction price, the amount actually paid rather than the amount billed, showed that average Medicare payments were 55 percent of the average private payment. The average billed price was \$44,525.¹³⁴ Medicare paid an average of \$13,195. Private payers paid \$24,046. Hospital billed prices and hospital transaction prices differ because Medicare reimbursement for extraordinarily costly patients is affected by what hospitals bill, rather than by what

Though traditional Medicare does not yet explicitly ration care, it can affect the service mix private providers offer its beneficiaries by changing reimbursement levels.

payers actually pay. High billed prices can also serve as a negotiating starting point with private payers.¹³⁵

In theory, Medicare providers should respond to losing money by limiting or eliminating money losing services. Though service cuts are difficult to track, especially if, as in the National Health Service, they are made in the ability to fund future improvements in care, limited research in the US suggests that Medicare payment reductions have been associated with deteriorating long run patient outcomes.^{136, 137, 138} In an ominous note for patients, hospital Medicare losses were expected to increase to 11 percent in 2019.¹³⁹

If private insurance disappeared and Medicare payments were the only payments available, hospitals would be unable to sustain current operations because Medicare does not reimburse enough to allow them to replace their capital assets. The Medicare Payment Advisory Commission estimated that most hospitals lost money on Medicare in 2017, with even the relatively efficient ones losing 2 percent. Some are already taking steps to reduce the proportion of Medicare patients they treat. In 2017, the Mayo Clinic announced that it would give priority to privately insured patients due to low Medicare reimbursement rates. Mayo said that it lost \$1.6 billion treating Medicare patients in 2016.¹⁴⁰

In the long run, even low reimbursements and hidden subsidies from private payers will not be enough to make the Medicare program solvent. At present, Medicare payroll taxes, taxes on benefits, and premium charges pay for only 57 percent of program expenses. General tax revenues pay for 43 percent.¹⁴¹ Over the next 30 years, taxes, premiums, and fees will cover a decreasing proportion of total expenditures and, as the graph below shows, Medicare, Medicaid, Social

Security, and interest on the federal debt are projected to consume all federal revenues by 2041.

Rather than focusing on ways to make Medicare more like private insurance—a government subsidy that provides protection against catastrophic medical expenses in old age but encourages people to save for expected health care costs in old age—those who discuss Medicare “reform” often limit their focus to searching for ways to lower government expenditures on the people currently trapped in the Medicare program.

An article in the journal *Health Affairs* provides a good illustration of this mindset. It examined variations in Medicare spending on patients with advanced cancer. To reduce expenditure, the authors proposed reducing “reliance on acute hospital care for this patient population” by motivating “health system changes to improve the value of advanced-cancer care.” No data were cited to show that the patients in the hospital should not be in the hospital. No data were cited to show that there were options other than the hospital that would make cancer patients better off. No consideration was given to the possibility that lots of qualified people are searching for less expensive options for “advanced-cancer care.” At bottom, the authors were simply recommending a reduction in hospital care for terminally ill patients because it cost a lot.¹⁴² If expenditures are continuously lowered and the state of medical technology remains the same, providing advanced medical care for Medicare patients will become a money-losing proposition for everyone, with fatal consequences for patients.

Because Medicare has a coverage monopoly, beneficiaries have no way to exert financial leverage over Medicare when its administrators make bad

...Medicare, Medicaid, Social Security, and interest on the federal debt are projected to consume all federal revenues by 2041.

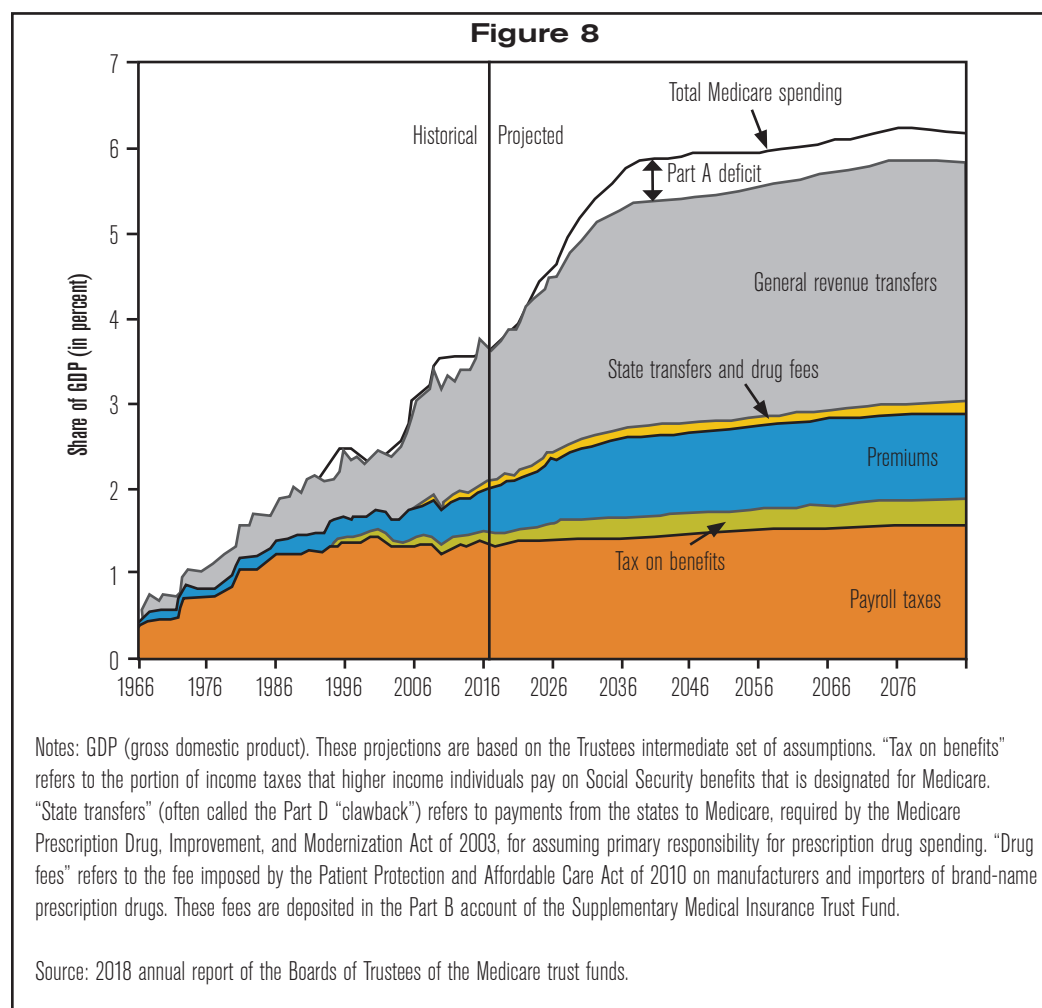
decisions. When efforts to control Medicare expenditures have unintended consequences, beneficiaries cannot avoid being made worse off by taking their premium payments and opting for a different benefits package or payment structure. Medicare patients are not even free to attempt to purchase better service by paying more out of their own pockets because Medicare prohibits participating physicians from charging patients more than the amount it agrees to pay them. Unlike private insurers, which have contracts with those who purchase coverage from them, and are policed by government, the Medicare “contract” changes whenever Medicare says it does, even if the change has never been tested, is known to be likely to do harm, and is little more than a political window dressing to respond to demands to “do something.”

Medicaid—Shifting focus from the sick and vulnerable to funding for health interest groups and state bureaucracies

Medicaid is an optional federal program in which states and the federal government share the cost of providing medical services for people with low incomes. On paper, it offers the most generous coverage in the United States because it provides coverage not generally offered in commercial plans and Medicare. It is relied upon by people who are too disabled, sick, or poor to care for themselves.

People have historically been eligible for Medicaid if they meet certain income or health requirements. The Affordable Care Act allowed states to expand Medicaid coverage to essentially healthy people

Medicare patients are not even free to attempt to purchase better service by paying more out of their own pockets because Medicare prohibits participating physicians from charging patients more than the amount it agrees to pay them.



with incomes of up to 138 percent of the federal poverty level. Medicaid is now the largest health coverage program in the United States with an annual average of 75.8 million people enrolled. After Colorado elected to expand Medicaid under the Obamacare rules, Colorado Medicaid enrollment grew from 500,000 people in FY 2009-2010 to about 1.3 million people in FY 2017-18.

States participate in Medicaid on a voluntary basis. In order to qualify for Medicaid, states are required to cover certain federally mandated benefits. If they do, the federal government pays a federal matching amount for each dollar a state spends. Federal matching fund percentages are calculated each year and vary by state income levels. In 2020, the base federal match is 50 percent, meaning that for every dollar a state spends on Medicaid, the federal government matches its spending with another dollar. In some states the matching percentage is much higher. Mississippi has a matching rate of 76.98 percent. The federal government pays it \$3.34 for every \$1.00 it spends on Medicaid.

States can opt to provide a selection of optional benefits eligible for federal aid, but not all states have chosen to do so. Many states have federal waivers allowing them to experiment with different ways to provide health care to Medicaid patients as long as their new programs do not increase federal spending. Optional benefits and state waivers combine to ensure that no two state Medicaid programs are the same. No one knows how well any of the waivers have worked. Both the states and the federal government have been more interested in expanding spending than determining whether existing spending provides reasonable value for the money and the quality of the evaluations of the new programs has been underwhelming.

In 2018, the Government Accountability Office concluded that evaluations of them suffer from a lack of “accurate, complete, and timely Medicaid data.”¹⁴³

States set Medicaid reimbursements for services provided to Medicaid clients, conditions for provider eligibility, treatment rules, and the structure of the system that delivers medical services to Medicaid patients. In order to save money, many states have low Medicaid reimbursement rates. There is strong evidence that low reimbursements make physicians less likely to see Medicaid patients, and that paying a managed care provider an annual flat fee for each patient leads to skimping on care to the sickest patients.¹⁴⁴ The effects of paying low reimbursement rates are compounded by the fact that Medicaid patients cost more to treat. They are more likely to miss appointments and it is illegal to charge them a no show fee. In a focus group of physicians conducted in Washington state in 2011, physicians said that Medicaid patients required more staff resources due to Medicaid’s paperwork, its slow reimbursement, and because of patients who needed more social and behavioral support from staff. Physicians were also frustrated by the fact that they could often do relatively little for their Medicaid patients as many needed specialist care that was not available. For these and other reasons, physicians may limit the fraction of Medicaid patients in their practices even if Medicaid reimbursement is the same as commercial reimbursement.¹⁴⁵

In Colorado and other states, some Medicaid providers are more equal than others. In addition to reimbursements that provide a fee for rendering a service, state Medicaid programs also give some Medicaid suppliers significant supplemental payments. These lump sum payments are awarded to hospitals and other providers by state governments

After Colorado elected to expand Medicaid under the Obamacare rules, Colorado Medicaid enrollment grew from 500,000 people in FY 2009-2010 to about 1.3 million people in FY 2017-18.

but are not tied to any care provided to a specific individual. In 2017, states spent \$46.3 billion on Medicaid supplemental payments.

When providers are funded by low reimbursement rates and large supplemental payments, they may be less concerned about the financial consequences of limited access and substandard care. Patients receiving poor care may be able to change the reimbursement substandard providers get by changing providers, but they typically cannot affect the award of supplemental payments. Patient opinions become even less important when Medicaid programs lock patients into managed care arrangements, thereby insuring that state appointed monopoly providers collect all reimbursements for care whether patients like it or not. In that case, Medicaid becomes a monopoly health provider run by government. Providers have more incentive to focus on pleasing the government administrators in charge of doling out supplemental payments than on pleasing the patients that are supposed to be their customers.

In Colorado, the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is the Taxpayer's Bill of Rights (TABOR) exempt enterprise that awards a large portion of the state's supplemental Medicaid payments. It receives money from the state provider "fee," a charge levied on people who use hospital facilities, and from long-standing federal programs to compensate hospitals for low Medicaid reimbursements. State government says the funds are supposed to compensate all hospitals for uncompensated care generated by low Medicaid reimbursement rates, and for patients who do not pay. Data from the Government Accountability Office tell a different story. In 2010, two Colorado hospitals received 82.6 percent of supplemental payments for

uncompensated care while providing just 64.8 percent of the total uncompensated care. Thanks to generous supplemental payments from Medicaid, they made almost \$24 million in Medicaid profits.¹⁴⁶

No one knows how those payments were used or whether they benefited either Medicaid patients or the taxpayers who provided them. In contrast, the 10 Colorado hospitals that provided 35.2 percent of total uncompensated care for Medicaid patients and the uninsured received just 17.4 percent of the state's supplemental payments.¹⁴⁷ The growing use of supplemental payments means that both reimbursements and supplemental payments must be tracked in order to estimate the total amount spent on Medicaid.

In health care as in any other industry, losing customers and the revenue that goes with them is the best way to discipline bad actors. When state government sets Medicaid reimbursements at an artificially low level and then pays favored hospitals large lump sums in grants, it ensures that facilities caring for Medicaid patients will be more concerned with pleasing the government than pleasing the patients. This sabotages patients' ability to enforce good behavior by taking their money elsewhere. There is strong evidence that higher Medicaid reimbursements benefit Medicaid clients by improving care and reducing shortages.¹⁴⁸ Medicaid clients would have more influence, and their care might improve, if supplemental payments were ended and the money was used to increase Medicaid reimbursements.

The Colorado Consumer Directed Attendants Support Services (CDASS) program provides a good example of how priorities and outcomes differ when patients direct health spending dollars. In Colorado Medicaid, state care managers determine how many hours

Providers have more incentive to focus on pleasing the government administrators in charge of doling out supplemental payments than on pleasing the patients that are supposed to be their customers.

of skilled home care Medicaid will give a disabled Medicaid client and the state paid contracts with private agencies who send attendants to clients' homes. After a year in the Medicaid program, disabled Colorado Medicaid clients have the choice to join CDASS or continue to receive home care from the contractors selected by the state under its regular Medicaid arrangements.

CDASS participants receive the money the state would have paid for their attendant care minus a financial management fee, so their budget for home care is slightly smaller than they would have received had they stayed in the standard Medicaid home care program. If clients choose CDASS, they must hire and pay for their own attendants. When CDASS Medicaid patients manage their own care, they buy more care and pay less, an average of \$16.68 per hour rather than the flat fee of \$28.26 per hour the state pays for skilled care. CDASS participants say they can save money by hiring less skilled people and training them to do the work they need.¹⁴⁹ Because they are picky about who they hire and they bear the costs of people who do not show up for work, mistreat them, or steal from their homes, people in CDASS report far fewer problems with no show attendants, attendants who mistreat them, and attendants who steal from them.

Private Payment—more attractive policies, lower premiums, more rapid innovation

Though government health programs are responsible for more than half of all US health spending, most Americans pay for their own health care. In 2017, an estimated 66 percent of Americans paid for care with private coverage or cash. People who directly purchased health coverage wrote a check for their premiums out of their after-tax income. Thanks to

the 1954 IRS ruling that made business payments for employee health coverage deductible as a business cost, Americans who purchase coverage through their employers pay for their coverage with pre-tax income through premiums and lower wages. This reduces the cost of healthcare covered by employer insurance, producing employer policies that have historically covered even relatively minor expenses like eyeglasses and routine dental care. People without coverage simply paid cash for their care or relied on government programs and charities. Care that wasn't paid for one way or another comprised an estimated 2.8 percent of total US personal health expenses in 2001, a default rate lower than the mortgage default rate in 2018.¹⁵⁰

Paying for health care using private coverage is more expensive than paying with cash because premiums must cover expected claims cost for the coverage provider's clients plus the overhead costs of administration, claims processing, and profit. People who purchase their own insurance and pay with after-tax dollars usually choose to minimize expensive insurance coverage. They typically purchase coverage for large expenses and plan to pay out-of-pocket for most routine care. People who purchase coverage through employers with pre-tax money generally purchase more of their health care through health insurance coverage and pay for less with cash.

Americans without formal major medical policies often have some coverage through short-term policies, auto insurance, workers' compensation programs, short-term health insurance, and critical illness policies that provide a lump sum of cash if a policy holder develops one of the conditions named in the policy. As figure 9 shows, when out-of-pocket payments for government programs and private insurance are included, American health

Though government health programs are responsible for more than half of all US health spending, most Americans pay for their own health care.

care has been exceptional because patients have historically controlled a much higher percentage of spending, more than 50 percent of all health spending, than in other industrialized countries. This likely explains why the US health system has been much more responsive to patients than the health systems in countries where patients have historically controlled a smaller fraction of total health system funding.

People buy coverage for a variety of reasons: to protect their assets from expensive health events that could cause large financial losses, to ensure that they can afford the care they need if they have a catastrophic medical event, and to make the demands on their household cash flow more predictable. Coverage allows people to benefit from the pricing power of companies that sell coverage to pay less for services from hospitals, laboratories, and physician practices. Companies providing coverage may also have valuable experience in arranging treatment for relatively rare conditions.

Before the Affordable Care Act standardized individual insurance policies, there were many different types of policies available to people who bought their own coverage. In states with sensible

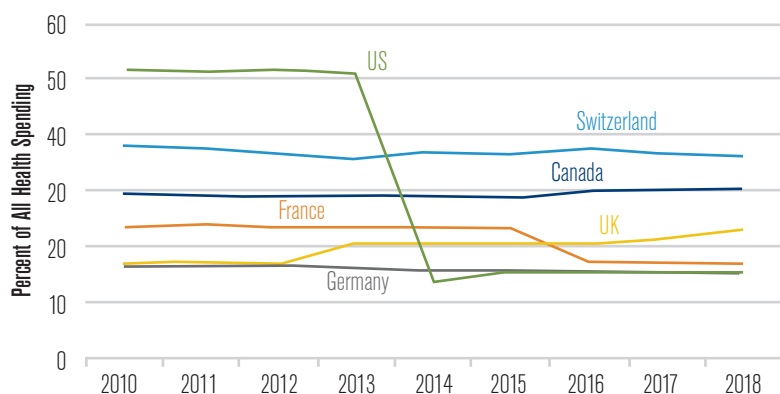
regulations, available coverage varied from \$45-a-month policies that covered hospitalization for children to nationwide networks that covered major medical and drugs with high lifetime limits, no copays or coinsurance, and a choice of deductibles. Some policies made financial exposure crystal clear by setting a single deductible for a whole household and charging no coinsurance or copays after the deductible was reached. Typical deductibles ran from \$2,000 to \$5,000 dollars, and people could buy increases in coverage limits, accident insurance to cover deductibles, and nationwide networks. As individual purchasers got older and their financial situation improved, they could increase their policy deductibles to keep their premiums down. People could change policy out-of-pocket limits at any time, modifying their premium payments as their circumstances changed without waiting a year for an arbitrary open enrollment season.

Because insurers were motivated to attract and retain healthy people, they offered a wide variety of policies designed to meet different needs. People could buy hospital coverage only, choose a deductible they could afford, pick a policy that had a zero deductible for accidental injuries, choose a policy with or without coinsurance,

Before the Affordable Care Act standardized individual insurance policies, there were a large variety of policies available for people who bought their own coverage.

Figure 9: Voluntary and Out-of-Pocket Spending as a Share of All Health Spending OECD, Selected Countries

(Due to the Obamacare individual mandate, the OECD reclassified US private insurance spending as involuntary spending after Obamacare took effect in 2014.)



buy coverage with a local or nationwide Preferred Provider Organization (PPO), purchase a policy that qualified for a tax preferred health savings account (HSA), or pay a monthly premium to belong to a Health Maintenance Organization (HMOs). People applied to an insurer for coverage, and after answering a series of questions on their health status they received a quote from an insurer on the price for a year's coverage. Most policies were guaranteed renewable once an individual was insured, and neither future policy renewals nor future premiums were dependent on health status. To keep less healthy people who were profitable because they paid higher premiums, insurers also had to offer plans that provided decent access to medical care.

at the same price as the healthy made coverage a poor deal for people in good health. They stopped buying coverage and reverted to paying cash for their health care. The Affordable Care Act (ACA) included an individual mandate because the people who designed it knew that healthy people purchasing health coverage were sensitive to premium prices. If they forced insurers to issue policies to people who were already ill at the same price they charged those who were not ill, premium costs would rise and large numbers of relatively healthy people would decide that paying for coverage they never used was too expensive, would stop paying for coverage, and would switch to all cash payment.

That is exactly what happened under the ACA. As ACA premiums began their inexorable increase, people who had previously paid for their own coverage fled the individual market, reducing unsubsidized enrollment in it from 11.8 million in 2013 to 7.7 million in 2017. As Edmund Haislmaier of the Heritage Foundation has pointed out, before the ACA

...the primary customers for individual-market insurance were Americans who were either self-employed or buying coverage between jobs. They were mainly seeking financial protection against potential future medical expenses

The changes made by the ACA attracted a new set of customers responding to the law's offer of subsidized insurance to pay for their current medical expenses. That skewed the post-ACA individual market toward a risk pool disproportionately consisting of older, less healthy, and costlier-to-insure individuals. In the first two years, hundreds of thousands

If individuals in poor health seeking coverage no longer pay for any of the above average expected future claims they will generate, then the cost of extra claims must be paid for by the other people who already have coverage.

Unlike people purchasing individual policies for the first time, people purchasing employer subsidized plans did not have their premiums adjusted to reflect their likely future health costs. The people who wrote the Affordable Care Act (ACA) regulations thought it would be good policy to extend this practice to the insurers who sold individual health coverage. Unfortunately, someone must pay for the increased expected health costs a relatively unhealthy individual poses for any given insurance pool. In the pre-ACA individual market, known increases in expected costs were paid for by charging higher premiums to relatively unhealthy individuals buying a new policy. After the ACA passed, premiums could not vary by health status, and insurers began using other means to discourage unprofitable people from buying their policies.

If individuals in poor health seeking coverage no longer pay for any of the above average expected future claims they will generate, then the cost of extra claims must be paid for by the other people who already have coverage. The requirement that insurers issue policies to the unhealthy

of costlier customers migrated into the individual market from other coverage. The results were sharp premium increases, that, in turn, prompted a growing exodus of unsubsidized customers.¹⁵¹

There were two main differences between the pre-ACA employer and individual insurance markets. The first was that people in the employer market have to be healthy enough to work. The second was that in the employer market, the extra premiums charged for insuring a relatively less healthy person were charged to the employer rather than to the individual. Employers distributed the costs of paying for the expenses of the relatively unhealthy to their insured employees as they saw fit and the law allowed—generally by paying employees lower salaries than would have been the case had the employer not offered health benefits.

Like individuals, smaller employers typically purchased fully-insured group policies from large insurers and the insurers bear all of the claims risk. Larger companies provided coverage through self-insured plans organized under the Employee Retirement Income Security Act of 1974 (ERISA). Fully-insured group policies were regulated by the states. ERISA policies were regulated by the federal government. In the market for individual insurance, individuals paid different premiums depending on their health. In the employer market, employers paid different premiums depending upon the health of their employee group. Group health costs vary from employer to employer. Some industries are more attractive to young people, others have working conditions that are more hospitable to unhealthy employees.

ERISA plans generally hire third party administrators for administrative services. They also protect themselves against high

unexpected medical claims by purchasing stop loss coverage, otherwise known as excess of loss reinsurance, from companies that specialize in pricing large health risks. Reinsurance companies examine the health of an employer group by examining employee claims history. They quote reinsurance premium prices based on expected future health expenses for the employer’s group, and past health claims are an important predictor of future health claims. Employers with high group health expenses pay more for reinsurance than employers with smaller group expenses. If an employer employs someone with exceptionally high health care costs, a reinsurer may “laser” that person, by requiring a higher deductible for his costs before the reinsurance begins covering high claims, or by simply refusing to reinsure any of his costs.

Before the Affordable Care Act, states with light insurance market regulation let markets set prices, allowed pricing based on health status, and minimized regulations telling insurers what had to be included in the policies they sold. State governments enforced laws about what health coverage must cover, when policies could be canceled, and when rates could be increased. In states that allowed insurers to price policies based on an applicant’s expected medical costs, often called medical risk, older people paid higher rates than younger people, seriously overweight people were charged more because they were more likely to incur medical costs, and women were charged slightly more because they used more health care. People with pre-existing medical conditions known to impose higher future costs were declined for new coverage, charged higher premiums, or were issued policies covering everything but the pre-existing condition.

As the table on the next page shows, premiums were much higher in states that experimented with the kinds of regulations

Before the Affordable Care Act, states with light insurance market regulation let markets set prices, allowed pricing based on health status, and minimized regulations telling insurers what had to be included in the policies they sold.

that became legal requirements under the Affordable Care Act. In New Jersey, an extraordinarily heavily regulated state in which insurers were required to cover any individual who applied for health coverage, individual insurance premiums were \$5,000 a month. At this price, coverage made sense only if one had an extraordinarily expensive health problem or wanted a policy to cover an expected medical procedure. In effect, heavy regulation turned the individual health insurance market into a bet on whether the cost of one's serious illness would be higher than average. People familiar with the effect of guaranteed issue and community rating in New Jersey and other states accurately predicted that the ACA individual insurance market regulations would do exactly what they have done—make premiums much more expensive, reduce the number of companies selling coverage, and reduce the number of people who purchase coverage without government subsidies.

Letting people purchase the coverage they wanted in competitive private markets

produced more attractive policies and much lower premiums. But before 1996, some people with employer insurance and pre-existing conditions lost their coverage through no fault of their own. They were unable to get coverage in the medically underwritten individual health insurance market because they had expensive pre-existing conditions that developed while they were working and had employer coverage, or because they had purchased individual coverage and their insurer failed or stopped selling policies in their state.

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) fixed the pre-existing condition problem by requiring states to provide an insurer of last resort for people who had paid for continuous coverage through their employer or an individual policy, lost that coverage through no fault of their own, and were turned down for commercial coverage. Employees covered under group plans already had the ability to continue health insurance with their employer for a limited time after leaving as a result of the 1985 Reagan Administration Consolidated Omnibus Budget Reconciliation Act.

Letting people purchase the coverage they wanted in competitive private markets produced more attractive policies and much lower premiums.

Table 8: Cost of Health Insurance: Family of four, husband and wife age 35 with two children, 2008

	Cost/Month	Plan Type
Heavy regulation		
Augusta, Maine	\$2,335	Anthem, \$1000 deductible
Springfield, Massachusetts	\$1,085	BC/BS HMO
Asbury Park, New Jersey	\$5,385	Horizon BC/BS, \$1,000 deductible
Chappaqua, New York	\$3,641	HIP HMO
Burlington, Vermont	\$1,613	BC/BS HMO
Lighter regulation		
Denver, Colorado	\$420.00	Anthem, \$1,500 deductible
Sacramento, California	\$504.00	Kaiser, \$1,500 deductible
Tallahassee, Florida	\$484.47	United, \$1,500 deductible
Columbus, Ohio	\$473.90	Medical Mutual \$1,000 deductible
Easton, Pennsylvania	\$337.52	HealthAmerica, \$1,250 deductible
Austin, Texas	\$569.00	Blue Cross/Blue Shield, \$1,500 deductible
Source: Brian McManus, Medical Savings Insurance and ehealthinsurance.com.		

Most states elected to provide coverage for the uninsurable through high risk pools, state arrangements that acted like standard health insurers but were heavily subsidized by a mix of federal funds, taxes on insurance policies, higher premiums, and general tax revenues. People could join the high risk pools at any time, limiting the damage done by prohibitions on buying coverage outside of open enrollment seasons. The higher premiums for high risk policies were necessary to provide an incentive for people to purchase standard policies before they became ill. Direct subsidies for uninsurable people kept premiums in the direct-purchase market relatively low compared to premiums for Affordable Care Act policies. In general, the cost of subsidizing uninsurable people using high risk pools was far lower than the cost of covering them under the Affordable Care Act with its large subsidies, high premiums, and enormous administrative cost.

The Cash Market— lower costs and lower expenditures

Although it is commonly asserted that the uninsured do not pay for their care, most Americans have low enough annual health expenditures that even people with moderate incomes can afford to pay for routine care without using health coverage. Academic estimates from the late 1990s and early 2000s suggest that the uninsured paid for about 65 percent of their care. People who were uninsured, a third of whom were eligible for Medicaid but did not bother to sign up until they needed care, tended to be younger and healthier. People with illnesses, and those who expected to need expensive medical care, were more diligent about buying coverage.¹⁵²

About 35 percent of spending on the uninsured was “uncompensated care,” and about two-thirds of that was received

from hospitals. But the uninsured who needed hospital care and did not pay for it were a relatively small group. Expenditures on them amounted to about 2.8 percent of total health spending, an amount slightly higher than the 2 percent of sales inventory “shrinkage” due to shoplifting and employee theft that plagues US retailers.¹⁵³ The rest of the health services provided to the uninsured were paid for by a mix of cash out-of-pocket payment, private charity, and public programs designed to pay for care for the uninsured.¹⁵⁴

Strong evidence now suggests that people who pay cash for care control their expenditures by using less health care, and carefully choosing the health care they do use. This was not the case in the 1960s when Medicare and Medicaid were under consideration. The prevailing school of thought then held that the amount of health care people used was a constant given their state of health, and that health care was a special good that markets could not supply efficiently. More specifically, those who designed the Medicare and Medicaid programs argued that the demand for medical services remained essentially the same regardless of the price charged. Those opposed to replacing private spending with public spending argued that people would use more medical care if their health expenses were paid for with other people’s money. People in favor of liberal government subsidies won the political battle, and Medicaid and Medicare were designed with low payments at the point of care.

The debate continued. In 1974, the US government funded the Rand Health Insurance Experiment to settle the debate about whether demand for health care varied with the amount people had to pay, and to determine whether people who had to pay would harm their health by forgoing medical care. RAND recruited

People who were uninsured, a third of whom were eligible for Medicaid but did not bother to sign up until they needed care, tended to be younger and healthier.

2,750 households containing 7,700 individuals, all of whom were under age 65. They were assigned to one of five types of health insurance plans created for the experiment. People assigned to the HMO-style group cooperative received all care free of charge. Of the four remaining plans, one offered free care and the others had cost sharing of up to \$5,000 in 2019 dollars. Sixty percent of participants had a physical when they entered the experiment, and all had a physical at the end. People participated in the experiment for 3 to 5 years.

The results showed that those who paid more used less care with minimal effects on their health. The people in the large deductible group used about 30 percent less health care than those who had free care. The Experiment could not document any significant differences in the average person's health that were related to the different amounts of utilization.¹⁵⁵ People with free care had diastolic blood pressure that was 2 mmHg lower because the additional physician visits made by people on free care made it more likely that untreated hypertension would be recognized. Once high blood pressure was diagnosed, those "under care at exit did slightly better with cost sharing than those with free care." But, as RAND

researchers pointed out, there were other, less expensive, ways to find hypertension than by providing everyone with free health care:

...although free care helped to control hypertension, giving free care to everyone is an expensive and indirect way to help a few. A simple screening exam, followed by notification of the subject's personal physician, accounted for more than half of the gain under the free-care plan at only a small fraction of the cost of giving free care to all.¹⁵⁶

As the Table 9 shows, people with free care were more likely to use the emergency department for relatively minor issues like ear infections, sprains, and headaches than people who paid with their own money. People with high cost sharing were much less likely to go to the emergency department for relatively minor conditions like headaches or sprains. When conditions were more serious, such as head injury, heart disease, or eye injuries, they were just as likely to use the emergency department as people for whom the visit would cost nothing. The RAND results predict that the uninsured will use emergency departments for conditions at rates similar

...people with free care were more likely to use the emergency department for relatively minor issues like ear infections, sprains, and headaches than people who paid with their own money.

Table 9: The RAND Health Experiment: Annual ER Visits Per 10,000 Persons

Condition	Cost Sharing Plan	Free Care Plan	Visit Ratio, Cost Share/Free
Surgical abdominal disease	42	38	1.11
Head injury	36	33	1.09
Chest Pain/Heart Disease	59	57	1.04
Acute eye injury	34	31	1.01
Asthma	30	83	0.36
Ear infection	40	78	0.51
Abrasion/contusion	228	403	0.54
Sprain	164	249	0.63
Headache	8	59	0.11
Source: Joseph P. Newhouse. 1996. Free for All? Harvard University Press, Table 5.2, p. 155.			

to those seen in insured people with high deductibles and evidence collected to date suggests that this is the case.

If Medicaid beneficiaries respond to incentives the same way that the people studied in the RAND Health Insurance Experiment do, one would expect people covered by Medicaid to use more emergency services. Coverage for Medicaid patients is similar to coverage for the RAND participants in the free care group. People with Medicaid coverage cannot be charged for using emergency services. If their income is under 150% of the federal poverty level (\$18,735 for a single person) and they go to the emergency room for a non-emergency, they pay a maximum of \$8.¹⁵⁷ Anecdotal reports suggest that collecting the fee is often considered more trouble than it is worth. Unsurprisingly, Medicaid patients rationally use a lot of emergency department services. Emergency rooms do not require appointments, are open 24/7, and offer all the tests one needs in one place. Why not use them if there is no charge and they are more convenient than going to a doctor's appointment?

As a result, expanding Medicaid almost always expands emergency department use, increasing expenditure and increasing cost. When Wisconsin created a new public insurance program for people with low incomes in 2009, emergency department use went up by 46 percent even though inpatient hospitalizations declined.¹⁵⁸ In states that expanded Medicaid under the Affordable Care Act, total emergency department use increased by 2.5 visits per 1,000 people, almost 9 percent, relative to non-expansion states.¹⁵⁹ The increase did not seem to be due to "pent-up demand." Other results from the Oregon Health Experiment lottery suggest that people respond to Medicaid's free care by increasing the average number of emergency department visits per

person. Emergency department use by people selected for Medicaid went up by 65 percent relative to those not selected for coverage, the increases persisted for two years, and emergency department visits may have increased in concert with physician office visits.¹⁶⁰

Evidence that people who pay cash economize on their use of health care also comes from reports of changes in behavior when employers change employee health plans. In one case, employees were switched from a zero deductible to deductibles as high as \$5,000 combined with a contribution of an equal amount to an individually-owned, tax-free, Health Savings Account. Like an IRA or a 401K, health savings account balances belong to an employee and accumulate tax free. This means that contributing to a health savings account rather than providing a zero deductible switches ownership of an employer's health coverage subsidy from the employer to the employee. Employees get to keep the money in the health savings account, tax free, even if they buy no health care. No taxes are owed on the money if funds from them are used to purchase health care approved by the Internal Revenue Service.

In one case, switching from essentially free coverage by a broad network PPO to a plan that combined a \$3,000 to \$4,000 deductible with an employer contribution of a similar amount to an employee's health savings account, decreased the employer plan's health expenditure by 12 to 14 percent over the next two years. Expenditures fell because utilization fell, not because patients shopped for lower prices or medical care suddenly cost less.¹⁶¹ As in the RAND Experiment, utilization fell both in categories classified as low value medical care and in categories classified as high value medical care.¹⁶² It is impossible to know whether people are making short-term choices that harm

Evidence that people who pay cash economize on their use of health care also comes from reports of changes in behavior when employers change employee health plans.

their long-term health or whether current classification schemes are incorrect about the value of various “services.”

Haviland *et al.* compared health plan expenditures for 54 large self-insured ERISA employer groups. Half of them offered plans that paired a high deductible with a contribution to a tax-advantaged employee health spending account. After tracking expenditure for three years, they found that the firms that had high deductibles and contributed to tax-advantaged employee plans enjoyed reduced health expenditure growth due to reductions in spending on outpatient care and drug spending.¹⁶³ Zheng *et al.* reported that groups with high deductible plans reduced diagnostic imaging expenditures by 10.2 percent for a sample of 21 million 2010 insurance claims.¹⁶⁴ The effects were confined to the third of the sample with the lowest risk. Once someone had one imaging study done, there was little difference in usage between plan types. It is important to emphasize that the

reforms that actually have reduced expenditures—employers who switched to plans that subsidized employees by raising deductibles and creating health savings accounts—are those that substitute cash for third party coverage where it makes sense, and do their best to ensure that the people getting the medical care treat cash subsidies as their own money. The Colorado Medicaid clients on Medicaid treat their CDASS subsidies as if it is their own because their lives depend on using it wisely. The employees who receive employer created health savings accounts treat the money as if it is their own because it does belong to them. The difference between cash and coverage is that cash accounts retain their value even if one buys no health care with them. Health coverage, whether provided by employers or the government, has no value unless someone uses health care.

Health coverage, whether provided by employers or the government, has no value unless someone uses health care.

Part VIII—Three Principles for Evaluating Proposed Health Care Reforms

As long as innovations continue to change medicine, no one knows how the US health care system should be structured and no one knows how much the US should spend on health care. All else equal, expenditures fall when people spend their own money. They rise when programs substitute government payment for private payment. The most that can be said is that payment flows need to reflect patient and provider judgments about the relative value of various treatments, the value of different modes of delivery, and the value of the various options that can be used to finance health care.

People who supply health care provide better care for less if they are free to sell their services as they see fit, try new modes of treatment, and explore new ways of providing care. Patients should be able stop seeing providers who treat them badly, removing their funding as they go.

When patients or providers find an innovation that makes patients better off, they should be able to reorient their spending to fund its growth. They may transfer money from other, less valuable, health products, or they may increase total health spending by spending more on health and less on something like transportation, housing, or leisure pursuits.

Government run systems are poor at innovation and poor at delivering quality care. They give patients little say in system structure, and have innumerable interest groups blocking financial reorientation. Even the smallest changes may require legislation or lawsuits. Although brute force rationing can reduce expenditure, there is little evidence that government control reduces cost. If anything, the opposite is true. Resource misallocations are common, and the proliferation of global budgets and entrenched providers reduces competition for patients, harms productivity, damages working relationships, reduces capital investment, and increases costs.

Before the Affordable Care Act, the Colorado individual insurance market had lower premiums, better networks, and less expensive coverage for people with pre-existing conditions. Imposing ACA rules on the individual market made sick people worse off by reducing their access to care and raising their premiums. The Affordable Care Act more than doubled premiums, raised taxes on health insurance, increased subsidies by hundreds of millions of dollars, did little to increase the number of privately insured, and “destabilized” the individual insurance market. The Colorado reinsurer subsidy program is just the latest example of a government program sold as lowering premium costs when in fact it increases health care costs overall by increasing taxes on hospitals and insurers in order to reduce the premiums that the government raised in the first place.

Had the US had a government run health system in the 1980s, outpatient surgery would have taken decades more to be adopted, hospital inpatients would still recover in wards, and patients might still be waiting months for diagnostic MRIs and CT scans. In Colorado, state Medicaid administrators have spent two decades trying to shut down the Consumer Directed Attendant Support Services program, possibly because patients who are free to spend Medicaid money allocated to their health care as they see fit make state programs look bad by demonstrating their higher costs and lower quality.

Principle 1: People use health care more wisely when they spend their own money on it, dividing their spending between cash and coverage in whatever way fits their situation.

As much as possible, people should finance their own health care with their own money, even if that money is augmented by a government payment or an employer contribution to a health savings account in place of a zero deductible health insurance policy. All forms of third party health coverage have more administrative overhead, and higher costs, than out-of-pocket payments from patients to providers. Paying cash eliminates the administrative overhead of collecting, recording, and processing premiums, verifying visits, coverage, and diagnoses, and determining whether a claim merits payment. When someone pays cash,

Before the Affordable Care Act, the Colorado individual insurance market had lower premiums, better networks, and less expensive coverage for people with pre-existing conditions.

Table 10: How People Behave When Buying medical care...		
	With their own money	With someone else's money
For Themselves and Their Loved Ones	Highly concerned with both quality and cost. Diligent search for the right balance between them.	Highly concerned about quality, low concern for cost.
For Strangers and Beneficiaries of Public Programs	Low concern for quality, high concern about cost.	Low concern for quality. Low concern for cost.

the provider gets immediate payment without filing forms or waiting for claims adjudication.

The best reforms will limit subsidies to people who are ill and cannot care for themselves, or for screening programs to find illness. Some people will need health care and be unable to pay for it. Consideration should be given to providing for them by subsidizing the institutions that care for them directly, preferably by streaming funds to the providers that actually care for specific patients rather than streaming federal funds to state governments that pay specific providers after they take a cut off the top for themselves and their preferred providers.

Government should not make it less expensive to purchase coverage through an employer than it does through the individual market. Government should not specify health insurance plan design other than to make sure that companies can make good on their contracts and can be prosecuted for shady business practices. It is much less expensive to pay cash for a mammogram than to prepay for “free” mammograms by paying high Affordable Care Act coverage premiums, and if people wish to do that rather than buying a policy that covers mammograms, they should not face financial penalties for cash payment.

A major problem here is that government entities have limited administrative capacity and a demonstrated inability to competently manage complicated subsidy programs. Individuals spending their own money are more likely to be alert to fraud and less likely to tolerate being billed for services they did not receive. In a 2017 report, the Health and Human Services Inspector General concluded that the federal government could have saved \$717 million just by requiring New York State to make sure that Medicaid Managed Long-Term Care plans comply

with contract requirements. It could have saved \$438.1 million by refusing to pay for medically unnecessary or improperly documented chiropractic services. Making sure that Florida stopped paying for dead Medicaid managed care, patients would have saved \$15.4 million. False clinics are another problem. A single network of Brooklyn-area clinics run by a doctor, a physical therapist, a chiropractor and two occupational therapists submitted \$100 million of fraudulent Medicare claims.¹⁶⁵

Principle 2: Programs that shift costs from one group to another with price controls, taxation, regulation, or mandates should be avoided

Programs that shift costs distort prices, making it impossible to know how much any health service costs. Managing programs becomes impossible because no one knows how much anything really costs. As far as possible, health care subsidies should be explicit, and payment should come from general tax revenues rather than from hidden taxes on hospitals, insurers, physicians, pharmaceutical companies, hospital patients, or other businesses or individuals.

In most cases, public programs should pay for services at roughly the same rate private parties do. Private claims data are widely available from health data vendors, and a commitment to use private market prices might reduce the amount spent to maintain huge bureaucracies to calculate Medicare and Medicaid reimbursements. Market payments for services rendered could help stimulate competition in rural areas by easing the strain on providers currently coping with below market payments from Medicaid and Medicare. Redirecting Medicaid supplemental grant money to increased reimbursements would let patients use their payments to signal the kinds of services they find valuable.

Government should not make it less expensive to purchase coverage through an employer than it does through the individual market.

Principle 3: Programs that substitute government spending for private spending will increase health expenditures, decrease innovation, and harm the sickest patients

The political incentives that control government spending almost always encourage government officials to skimp on expensive health care for the sickest people. Seriously ill people are a small fraction of the voting population at any one time. From a political perspective, it makes more sense to concentrate spending on services used by the median voter than on those who are seriously ill and may not be alive for the next election. As a result, politically controlled systems typically are unwilling to spend as much money on seriously ill people or disease prevention as individuals would like. If the amount budgeted for health care is fixed, it also becomes difficult to increase spending when a new discovery leads to a valuable new treatment.¹⁶⁶

Programs financed by tax revenues also create deadweight economic losses by reducing the production of the goods that are taxed and increasing consumption of the goods that are subsidized.

For too long, people intent on reforming US health care have treated private health care as the enemy, an expensive system that needs to be replaced by government payments and government care. They have falsely claimed that government run health systems in other countries produce better quality health care at lower cost by ignoring waiting lists, minimizing the poor treatment given the sickest people, hiding high out-of-pocket costs, and ignoring the lower rates of innovation and living standards characteristic of countries suffering from the rigidity and deadweight losses caused by tax financed health care.

Clear evidence shows that mostly private health care systems in which people spend their own money on the health care they want, using the financing arrangements that make the most sense to them, provide better care at lower cost. When potential patients control the funds, health care suppliers compete for business, emphasize rapid diagnosis and treatment, provide better care for the sickest people, and innovate rapidly. Reforms worth supporting will resist expanding government health payments and seek to eliminate programs and regulations that shift costs, impose unnecessary regulation, and funnel support to healthy interest groups at the expense of taking care of those who are ill and cannot care for themselves.

Clear evidence shows that mostly private health care systems in which people spend their own money on the health care they want, using the financing arrangements that make the most sense to them, provide better care at lower cost.

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