White Paper on Medical Financing

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ABSTRACT

There has been no free market in American medicine for some 60 years. Voluntary, mutually advantageous exchanges between buyers and sellers have been impaired by government intervention. The patient-doctor relationship has been eroded or superseded by third-party contracts, as true insurance has been turned into prepayment schemes.

The drive for "reform" to accomplish "universal coverage" through subsidies and coercion will only exacerbate current problems, including cost inflation with diminishing quality and access. A proper understanding of rights and responsibilities is essential in formulating policy that will free medicine and defeat efforts to impose top-down, centrally planned command-and-control medicine on all Americans. Government—with the distortions it has imposed on the medical and the insurance market—is the problem, not the solution.

Preserving the right of patients to self-insure and to privately contract for medical services is critical. Discrimination against self-paying patients is a serious problem: Antitrust provisions and protections modeled on right-to-work laws could help to counteract this.

The Drive to Universal Coverage: the Massachusetts Plan and Other Reform Proposals

There is a concerted, nationwide push to force Americans to purchase health insurance. Massachusetts enacted a plan of mandatory health insurance for all. The AMA just endorsed mandatory insurance for those who, in its view, can afford it (defined as those with an income at or exceeding 500 percent of the federal poverty level: individuals earning at least $49,000 or families of four earning $100,000).[1] Tennessee, while pretending to reject the Massachusetts plan, is considering new taxpayer-funded insurance. Editorials and columns in newspapers around the country, from California to Texas to New York, are calling for government to coerce citizens to buy insurance for themselves and/or for others.

Coerced purchase of insurance is the first step in the plan for universal coverage. Once everyone is forced to buy insurance, the insurance companies can consolidate, or act like an oligopoly under government regulation. Inevitably, the end long sought by socialists will be realized: single-payer insurance regulated by the government.

The Massachusetts plan requires everyone over age 18 to purchase health insurance by July 1, 2007. A state fund exists to subsidize those judged to be unable to afford health insurance. Penalties will be imposed through the state income tax on those who, in the state's opinion, can afford to purchase insurance but do not do so. Most qualifying plans will have to include expensive state coverage mandates that many people would reject if allowed to decide for themselves.

Premiums are estimated to run up to $500 per month per family, and $200 per month per individual. Although these, like other government actuarial estimates, will probably be shown to be far too low, there is no accountability, even for serious miscalculations.

The law creates more state agencies with staff and other expenses to be paid by the taxpayer, including the Commonwealth Health Insurance Connector, which is to connect the "uninsured" with private insurers and enable small businesses to purchase insurance as a group. The Massachusetts legislation[2] is 150 pages long, designed in part by the Heritage Foundation, which applauds what it apparently considers to be a free insurance market for buyers. However, the Connector bureaucracy must certify that all products are of "high value and good quality," and current mandates are "protected."

Massachusetts lawmakers estimated that the cost of their mandates would be $316 million in the first year, and $1 billion by the third year. Real costs will likely be higher, but we will not know until around 2010. By then we may have even more chaos in medical practice as physicians see the possibility of a total government takeover.

The Massachusetts law forces employers having more than 10 employees to offer health insurance to their employees or pay $295 per employee per year for failure to do so. The governor vetoed this provision, but the legislature overrode this line-item veto. A more serious problem for small business is the requirement to pay employees' medical bills that exceed $50,000, if the business does not offer insurance (the "free-rider surcharge").

The vote in Massachusetts was nearly unanimous. Republicans are desperate to show that they are doing something to alleviate the perceived crisis. Democrats favor the elimination of the self-paying, free-market patient who is not under their control, and could easily view this law as a giant step towards single-payer or government control of medicine. "Already there are those ready to clone it for Texas or Iowa or Oregon, or even supersize it for the whole of the nation and its estimated 46 million uninsured," wrote Allen Pusey for the *Dallas Morning News* on June 11, 2006.

An unusual set of circumstances facilitated passage of these mandates in Massachusetts. Unlike most states, Massachusetts has a $1 billion fund for defraying healthcare costs for the uninsured, supported by federal matching funds, healthcare taxes, tobacco settlements, and other state sources. Its uncompensated care waiver from the U.S. Department of Health and Human Services (HHS) was expiring, and the federal government threatened to withhold $385 million in federal subsidies unless Massachusetts reformed its system, which passed huge amounts of funding to a few hospital systems and "often lacked accountability."[3]

Massachusetts has a higher per capita income, and lower uninsured population, than most states. Compared to California, for example, Massachusetts has a nearly 20 percent higher per capita income, and an uninsured population of only 11 or 13 percent (statistics vary) vs. 21 percent in California and 16 percent nationwide. Even more striking is that 71 percent of the population has employer-based insurance in Massachusetts, compared to only 57 percent in California.[4]

Massachusetts is not the first state to attempt to force some employers to provide health insurance to their employees. Earlier, Maryland passed a law requiring employers with more than 10,000 employees to spend at least 8 percent of their payroll on employee healthcare. The law was structured so that only Wal-Mart is affected, to the delight of unions that dislike Wal-Mart. Since this bill passed, 29 states have considered similar "Wal-Mart bills," though they have not yet passed. A federal court has ruled that the Maryland law is pre-empted by ERISA, although the judge suggested ways of circumventing this problem.[5]

After the Massachusetts plan was enacted, Tennessee considered its options under a Democratic governor who has a health insurance background. While Tennessee is comparable to Massachusetts in population and the number of uninsured, Tennessee is closer to the other end of the political spectrum. For example, Tennessee lacks an income tax, although it did have one of the most liberal health plans (TennCare). Gov. Phil Bredesen declared his solution to be the opposite of the Massachusetts remedy. But is it?

Like the Massachusetts plan, the proposed Tennessee plan calls for taxpayer-funded insurance, and also has government rationing to control costs. "The Cover Tennessee plan calls for a $150 monthly premium for basic health insurance, with the state paying $50. The individual would be responsible for the remainder, though businesses would be given the option of paying half," explains Associated Press reporter Erik Schelzig. "The program would limit benefits, for example the number of nights for hospital stays, instead of requiring a high deductible to keep costs down for the insurer."[6]

AAPS Director Robert S. Berry, M.D., notes that "Bredesen's plan will do little more than shift money from Tennessee taxpayers to insurance companies and their executives." Care will certainly be limited, he notes, especially considering how limited it already is for TennCare recipients for whom taxpayers pay $6,000 per year rather than $1,800.[7]

The march towards universal taxpayer-funded "health care" is in full swing. It will not be derailed by minor changes to the status quo. We must find an alternative proposal for basic reforms.

A Semantic Note on "Uninsurance"

Although the term "uninsured" (and the *Alice-in-Wonderland* noun "uninsurance") is so widely used that it is impossible to avoid, we believe that the term "self-paying" or "self-insured" is more accurate. Many persons have deliberately chosen to risk assets or future earnings rather than buy medical insurance; only a fraction of them intend to steal services from medical facilities and practitioners in the event of illness or accident. Many medical bills of self-insured patients are paid, in whole or in part. Many medical bills of insured individuals are not paid, or are paid at a rate of a few cents on the dollar. Persons with a relatively high deductible are self-insured for amounts less than the deductible and should not be assumed to be "underinsured." Current distortions in terminology reflect the tendency to equate insurance with medical care and to assume that third-party payment is the only, or the only acceptable, way to pay medical bills. This tendency helps to move the United States closer to the objective of the central control of medicine by government or by agents acting under tight government control.

The Requirements for True Free-Enterprise Reforms

The **goal** of true reform should be to optimize access to care, stimulate quality improvements, and lower costs—not to "equalize" access by leveling down and assuring misery for all; not to impose uniformity and conformity; and not to redistribute wealth to achieve "social justice."

The **principles** are:

1. Individuals and families have a *responsibility* to provide for the necessities of life, including medical care. They do not have the *right* to force others to provide for their needs.
2. Resources should be allocated on the basis of *value to recipients and suppliers*, who are free to buy and sell goods and services without government interference, as reflected in honest prices. They should not be rationed according to a political formula determined by the government.
3. Dead-weight administrative costs, such as filing claims for routine expenses, should be greatly reduced. Most payments should be made directly by the patient to the provider at the time of service.
4. Most funding should be private. Any government (taxpayer) funding should be restricted to the truly needy and should be through taxes borne equally by all, not through hidden charges and preferences, or debt imposed on the next generation. In particular, insurers, hospitals, physicians, or self-paying patients should not be forced to fund government initiatives through cost shifting.
5. Subsidies should generally flow through patients, not providers.

6. The economic effects should be to create a favorable climate for business and employment, rather than increasing the costs of providing jobs through the imposition of benefits mandates.
7. The effects on the medical economy should be equilibrium between supply and demand, a wide variety of medical and insurance choices, and flourishing innovation.
8. The principles of insurance should be adhered to, not flouted: true insurance is a voluntary sharing of the risk of *catastrophic* loss, with premiums based on risk. It is not a mechanism to pre-pay routine costs through a third party, or to redistribute wealth. Social welfare must be kept separate from insurance.

The Right to Self-Pay and Self-Insure

To protect against the denial of care that is inevitable in any government-controlled system, it is essential to protect the absolute right of any patient to self-pay for medical services—including those purportedly "covered" by the plan but inaccessible because of queues, deliberately limited supply, price controls, or denials on the basis of "futility," lack of "medical necessity," or exclusion from an "evidence-based guideline." This right is meaningless to patients unless providers are free to accept direct payment.

Americans may assume that they will always have the right to buy medical care if they wish. However, many have forfeited this right through "hold harmless" clauses in insurers' contracts. Insurance companies are increasingly trying to restrict access to medical care by preventing patients from paying out of pocket for "covered" services that are denied in a particular case. Insurance companies thus override the judgment of physicians by ruling not only on what they will pay for, but on what care a patient may receive.

The Maryland statute incorporates wording developed by the National Association of Insurance Commissioners. As quoted by the Maryland attorney general in an analysis prepared for the Maryland Senate, it requires that:

> The provider may not, *under any circumstances*, including nonpayment of moneys due the providers by the [HMO], insolvency of the [HMO], or breach of the provider contract, bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from, or have any recourse against the [HMO] member ... for services provided in accordance with the provider contract [emphasis in original].[8]

Pennsylvania regulations require that plan and health care provider contracts must contain a statement that "the hold harmless language supersedes any written or oral agreement currently in existence, or entered into at a later date, between the health care provider and enrollee, or persons acting on their behalf" [28 Pa. Code §9.722(e)(1)(ii)].

As a result of such a clause, Sandra Lobb was refused admission to an alcohol rehabilitation program when her insurer, Independence Blue Cross (IBC), denied payment, even though her physician advised it and her family desired to pay privately. Her physician stopped treating her because the provider contract obliges physicians to "participate in, cooperate, and comply with all decisions rendered in connection with Independence's Utilization Management Program." Mrs. Lobb then died.[9] A Pennsylvania Superior Court upheld the right of IBC to override the judgment of the attending physician.[10]

Correspondence between Aetna and a persistent small businessman confirms that patients are allowed to self-pay only for explicitly non-covered services such as cosmetic or experimental procedures.[11] The rationale is probably to prevent lawsuits by patients who were denied authorization for services that they decided to purchase themselves, and from which they clearly benefited.

This means that many younger Americans are effectively in the same situation as Medicare patients, who are not legally able to purchase covered care outside the constraints of Medicare rules (including price controls and the ban on balance billing), if enrolled in Part B, unless they see an opted-out physician (one who has agreed not to receive any Medicare funds for two years).

Patients should be free to self-insure for part or all of their medical risks and to choose their form of insurance. Some patients may prefer to assume the risk that they will incur indebtedness if they elect to post-pay for care rather than accepting the high probability of overpayment if they pre-pay through insurance. (The "free rider" problem is considered below.) Patients are and must be free to decline medical treatment: As with other economic goods, there are always trade-offs between costs and benefits. It is unjust to force patients to pay for treatment they choose not to receive. Individual patients' values and levels of risk tolerance vary greatly.

Many Americans are already choosing voluntary *non*insurance programs—such as Christian medical cost-sharing programs. Contributions are substantially less than insurance premiums. Other religious groups or fraternal organizations could also offer such plans.

Mandatory automobile insurance laws are frequently cited as precedent for mandatory medical insurance, to protect the public against being forced to pay costs imposed by others. For several reasons, the comparison is not apt. First, many persons do not drive or own an automobile, and they need not buy insurance. Second, no one is required to insure against his own financial loss in a car crash, only that of others injured through his fault. Automobile insurance protects the victim of a tort from an insolvent tortfeasor; torts and illnesses are not comparable events. It is noteworthy that about 15 percent of motorists do not have current insurance even in the presence of the mandate[12]—about the same as the percentage of persons without medical insurance. Even some persons who have assets that could be lost in a lawsuit choose not to protect them through insurance.

Additionally, states that require auto insurance typically have provisions exempting those who self-insure. Ohio and Washington permit the use of bonds or certificates of deposit in lieu of auto insurance. See, e.g., ORC Ann. 4509.45. The amount is often the same as the minimum amount of auto insurance, which is $60,000 in Washington State.[13] Arkansas has a full exemption from the

requirement on the basis of religious belief. A.C.A. §27-19-107. Proof of assets equaling the minimum level of mandatory coverage should satisfy the insurance obligation. This should be easily met by anyone who owns a house.

The Obligation to Pay for Medical Care

Medical care obviously must be paid for, and those who present themselves for or accept medical treatment are implicitly accepting a contractual responsibility to pay for it. The state has the right and the duty to allow enforcement of obligations of contract.

Those who cannot or do not meet their obligations ("free riders") can seriously threaten the availability of services and greatly increase costs to others. Some hospitals are being forced to close or curtail services because they cannot collect for services rendered. Physicians are limiting services or leaving certain areas because of the nonremunerative work demanded of them. Services that people do not value (i.e. for which they are not willing to pay) will sooner or later become unavailable. Enslaving or impoverishing physicians will simply drive competent persons out of the profession.

Self-paying patients are not the primary cause of the financial problems of American medicine. Many "uninsured" patients pay out of pocket for their care, and "uncompensated care" accounted for only 2.8 percent of total personal health spending in 2001.[14] Additionally, the figure for uncompensated care may be based largely on grossly inflated "chargemaster" prices, as discussed below.

All enterprises face losses from theft and bad debt. Medical enterprises also face heavy burdens imposed by government price controls and unfunded government mandates, which prevent them from withholding services from persons who do not pay. Reform is urgently needed to make these costs transparent, and to deal with them fairly. In the meantime, self-paying patients should not be disproportionately burdened.

Overcharging the Self-Paying Patient

Hospitals may claim to charge everybody the same "chargemaster" rate, but they then give huge discounts to government and certain insurers. The effect is to demand many-fold higher prices from self-paying patients, or those with high deductibles. In this way, insurers help create the very peril against which insurance is meant to protect. People may feel compelled to buy much more insurance than would otherwise be considered necessary or economical. Price discrimination against patients who pay their bills directly, without the third-party intermediary, jeopardizes the success of efforts to restore true insurance, including the "consumer-directed health care" movement, which emphasizes tax-advantaged Heath Savings Accounts (HSAs). It should be noted that, in general, hospital behavior is severely distorted by government regulations and price controls, especially Medicare.

Better access to pricing information would discourage price discrimination against the self-paying patient, particularly in a competitive market. Government policy concerning subsidies, tax-exempt status, referral of government employees, or other government benefits (including Medicare funding) should be tied to policies that treat self-paying patients fairly. Legislative remedies should include antitrust provisions and laws modeled on right-to-work laws, as discussed below. These could help to counterbalance the heavy government-conferred advantage enjoyed by large conglomerates, such as use of the antitrust law against physicians but not the "business of insurance," owing to the McCarran-Ferguson exemption, as well as barriers to market entry by insurers or medical facilities.

Model Antitrust Provision

Insurers use their market clout to force hospitals to sign contracts that disadvantage patients who do not purchase their product. The ever-increasing consolidation of insurance companies should subject them to regulation under antitrust laws.

A model provision is as follows: "Any express or implied agreement with an insurance company concerning prices charged to the self-paying patient shall constitute unlawful restraint of trade and be actionable."

An advisory to hospitals to "end all discrimination against the self paying patient" could encourage hospitals to make additional voluntary changes to their policies. Also, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) should be encouraged to modify its existing nondiscrimination policy to read: "The hospital must not discriminate on the basis of age, gender, race, ethnicity, national origin, sexual orientation, disability, *or payment method*." JCAHO accreditation is "voluntary," but is an eligibility requirement for participation in many government funding programs.

Urgently needed is the restoration of contestable markets: markets in which specialty hospitals, outpatient centers, and other arrangements can offer competitive services with minimal interference from government.

The Right-to-Work Paradigm

The economic problem of a self-payer with respect to capital is comparable to that of a non-union worker with respect to labor. Both face pressure by third-party monopolies, or near-monopolies, to drive them away from their independence and into the hands of the monopolist. To learn how to preserve free enterprise and the rights of the individual, we need look no further than the "right to work" laws that protect the rights of the individual, non-union laborer.

Thanks to the Taft-Hartley Act of 1947, which was passed by a conservative Congress over President Truman's veto, each state can

enact laws to protect the rights of the individual, non-unionized laborer. Twenty-two states have done so.

Conservatives or libertarians, to the best of our knowledge, do not criticize right-to-work laws, which ensure full rights of an individual, non-unionized worker in the labor market. These laws prevent a union from agreeing with an employer to hire only union workers; prohibit a union from ever charging or even receiving payment from a non-unionized worker in return for the privilege to work; and ensure that a non-unionized worker can be employed on terms competitive with union labor.

Texas laws are typical: "A person's inherent right to work and to bargain freely with the person's employer, individually or collectively, for terms of the person's employment may not be denied or infringed by law or by any organization" (Texas Codes Ann. Title 3 § 101.003). That prohibits a union from cutting a deal with an employer that interferes in any way with the employer's hiring and paying non-union labor. The right-to-work laws in any of the 22 states that have them are available at www.nrtw.org/rtws.htm.

In medical care, individuals also need the right to privately contract. While insurance companies have the right to bargain with hospitals and other providers, they do not have the right to dictate the terms that may be offered to others, including self-paying patients.

Agreements that have the effect of inflating the prices charged to self-payers are an economic interference with the right to contract and should not be allowed, just as right-to-work laws prohibit any interference with an individual's right to bargain freely with an employer. Disproportionate discounts based solely on the source of payment (the equivalent of price inflation to those denied the discounts) are distinguishable from economically rational discounts based on factors such as prompt payment, assured payment, or steering a volume of business. Self-paying patients may be charged a price that is grossly disproportionate to any excess costs of their care or any economic benefits of caring for a group of "covered lives." Medical care must be individualized, and economies of scale that justify volume discounts are therefore limited.

A "right to contract individually for medical care" law would be analogous to right-to-work laws. It would provide that: "Any agreement, understanding, or practice, written or oral, implied or expressed, between any hospital and insurance company that shifts higher costs to the self-paying patient is hereby declared to be unlawful, null and void, and of no legal effect." For enforcement, "A self-paying person who is overcharged in violation of this provision may obtain treble damages plus attorney fees, and a class action may be brought on his behalf."

While hospital contracts with insurers are generally kept highly confidential, interviews with hospital officials revealed that "they were reluctant to bill the uninsured for less than full charges because of insurers' common negotiating practice of insisting on being charged the same as the lowest-paying customers."[15]

Additionally, this approach provides a way to protect patients' rights to self-pay for services that are "covered" but denied: "No hospital or medical facility may refuse to accept payment from a patient based directly or indirectly on a contract with an insurance company."

The Proper Role of Insurance

It is desirable for most persons to have insurance against catastrophic expenses, to protect availability of care to the community, and to shield patients from lifelong indebtedness and taxpayers from the burden of paying for uncompensated care. To achieve this, states should encourage the development of low-cost catastrophic insurance and repeal all laws and regulations that prevent the offering of high deductibles or coverage restricted to accepted treatments of life-threatening or disabling conditions.

Any state subsidies to purchase insurance should be used only for insurance with a deductible higher than the amount non-Medicaid-eligible persons could cover with sale of personal property or wage garnishments or borrowing over a reasonable period of time: say $20,000. "Bridges" to cover the deductible, preferably with funds owned by the individual, should be encouraged. Examples: health savings accounts; flexible spending accounts that can roll over tax-free; short-term, limited insurance to cover up to the deductible while savings are accumulating; low-interest medical loans; and self-insurance by employers. ***Desirable payment mechanisms allow the economizer to benefit from the economizing.*** That is, the patient should benefit from prudent shopping, not just the insurer. If the insurer is left out of the equation altogether, as in cash-only clinics, patients can benefit from substantially lower administrative costs.

We oppose state-mandated insurance. There is no constitutional authority for government to supervise the means by which citizens meet their fiscal responsibilities, as long as they act in a lawful manner. Mandates distort and impede the process of voluntary, mutually beneficial exchanges (called "the market"). Moreover, enforcement costs are a dead-weight loss.

Although insurance fills a useful social role, over-insurance or pre-paid medical care distorts the marketplace, encouraging overconsumption and causing disproportionate price increases. Tax policy should not encourage over-insurance. A strong case can be made for repealing all tax preferences for health insurance, with an accompanying cut in the total tax rate. An alternative would be to end tax discrimination that favors employer-owned, low-deductible policies, and disfavors personal ownership of insurance and self-payment of bills. Medical expenditures should have equivalent tax treatment, regardless of the mode of payment. HSAs are a step in the right direction.

The Design of Insurance Benefits

In a free economy, government does not attempt to design a one-size-fits-all benefits package and then force it on citizens in an uncontrolled experiment. There are many potential ways to reduce costs and minimize the moral hazard of insurance. There is no

possible benefits design that will guarantee full protection of all against all possible hazards, or eliminate the need for a social safety net, such as family, church, or community charity. The optimal solution cannot be designed. Pluralistic solutions must be allowed to develop through free-market competition among many different plan designs, some probably not even contemplated at present. Charity should also be encouraged. The main role of insurance regulators should be to assure that insurers are fiscally solvent and that they provide honest disclosure about their products and comply with their contracts.

Patients would have a greater choice among insurance products if it were not for insurance monopolies or near monopolies, along with state regulations setting up a high barrier to market entry. To make monopolies difficult to maintain, to keep special interest groups with legislative influence from forcing subscribers either to pay for their favored procedure or forgo insurance altogether, and to encourage rational regulation, all Americans should be allowed to purchase insurance across state lines.

Possible product designs include:

- An "allowance payment toward" or APT, with insurers developing tables of allowances for various conditions or procedures. Excess indemnification could be used to offset other costs of being sick (such as loss of income). Demands for treatment above and beyond the allowance would subject the subscriber to balance billing.
- Various schedules of deductibles and copayments.
- Rebates to subscribers who choose less expensive options.[16]
- Critical illness ("dread disease") indemnities.
- Broadened "Good Samaritan" protection for serving patients at no charge or greatly lowered charge.
- Tax credits or deductions for providing uncompensated services.
- Expanded options for free treatment in exchange for participation in clinical trials.
- The purchase of medical time shares. (This innovative proposal under development by doctors John and Alieta Eck offers a certain number of days annually in a hospital to owners who have, for example, purchased a share for $30,000. The hospital, as currently envisioned, would be in a desirable but low-cost offshore resort.)
- Package deals for treatment of specified elective conditions in specialized facilities, including offshore hospitals.
- Lifetime health insurance.

The insurance industry can surely develop many excellent and innovative products if permitted to work out ideas without government interference.

Safety Checks on Any Proposal

Because legislative reform usually has unintended consequences, it is crucial that reforms have a "sunset," or expire automatically unless explicitly renewed.

All relevant government agencies or boards should have transparent budgets, with provisions for public inspection of financial records. Cross subsidies should be made explicit. Automatic checks should be imposed in the event that government expenditures exceed the budget.

The ultimate social safety net in any system dependent on the political forces that affect government funding or third-party payment is the availability of services for direct payment, as in cash-only clinics.[7] No system should be considered that impairs the basic rights to life, liberty, and property exercised in buying medical care with one's own resources.

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