

# **Limiting Government and Empowering Consumers: A Review of *America's Health Care Crisis Solved***

By Justin Jenkins

In their insightful 2008 book entitled *America's Health Care Crisis Solved: Money-Saving Solutions, Coverage for Everyone*, J. Patrick Rooney and Dan Perrin sound the alarm on “a very large and menacing iceberg that lies directly in our path”<sup>1</sup> — the uncontrollable rising costs of U.S. healthcare. The solution, write the authors, is to revamp the health system to place more control in the hands of individual Americans. Every state and federal legislator would do well to read this book.

High health care costs trace their origin to World War II, during which the federal government implemented wage and price controls. Wage controls forced businesses to attract workers by alternate means, such as offering to pay for employees' health coverage. With employer-funded premiums and no deductibles, Americans grew dependent upon insurance to cover their medical needs. Over time, hospitals raised the costs of care, obligating insurance companies to compensate with higher premiums. As a result, the costs of today's hospital care, physician services, prescription drugs, and health insurance are through the roof.<sup>2</sup> “In 2005, the United States spent \$2 trillion on health care, about 16 percent of the gross domestic product, or nearly \$6,700 per person,” and the average insurance premium is an outrageous \$1,008.83 per month, or \$12,106 per year.<sup>3</sup>

According to Rooney and Perrin, living without health insurance means running the risk of being grossly overcharged for services rendered at American hospitals. “The unwritten rule is to avoid the uninsured when possible, and when not, gouge them with prices three to five times higher than what others pay.”<sup>4</sup> In their effort to make money, a large majority of both nonprofit and for-profit hospitals exploit the uninsured, those in the weakest position to fight back. One California hospital reportedly collects \$2,563 per day from certain managed-care insurers, compared to a whopping \$8,535 per day from the uninsured, even though the hospital's operating cost amounts to only \$2,172 per day.<sup>5</sup>

What is the solution to a system that threatens the availability of affordable health insurance and health care to millions of people? For Rooney and Perrin, the answer is certainly not found in state or federal government-managed programs, which have historically served only to create inordinate delays in provision of care, produce inefficient and wasteful spending, drive up private insurance costs, encourage needless and excessive consumption of medical care, and remove decision-making power from individuals.<sup>6</sup>

Moreover, by subordinating quality of care to minimization of costs, managed care programs — and even some private insurers — frequently compel enrollees to accept bare bones treatment and avoid more expensive but desirable doctors or services.<sup>7</sup> “No one wants routine,

cheap medical care for the sake of saving money,” the authors write. “We want *effective* medical care so we can get well.”<sup>8</sup> How is this to be accomplished?

Instead of looking to government, Rooney and Perrin propose a series of six reforms that would “bring the self-interest of the American consumers into the purchase of health care.”<sup>9</sup> These proposals include Fair Care, health savings accounts, price transparency, hospital accountability, state-risk pools, free markets for insurance, and quick-care clinics. The two most essential of these reforms are Fair Care and health savings accounts.

Fair Care is a federal program which would provide a tax credit to people choosing not to enroll in government health care. The Fair Care recipient could either invest his tax credit in a health savings account (discussed below) or put it towards the purchase of private insurance. Under the current system, money spent by employers to pay for employee health insurance is exempt from income or payroll taxes.<sup>10</sup> That means that “the more highly paid Americans . . . are getting a tax credit in a different form.”<sup>11</sup> Fair Care would give each person — including but not limited to high-income earners — an opportunity to receive tax relief to purchase the health coverage that meets his needs. The loss of revenue produced by the tax credits could be compensated in large part by the \$260.1 billion that could be generated this year by discontinuing tax-deductions given to employers for the cost of employee health coverage.<sup>12</sup>

Rooney and Perrin offer a second major solution to the health care crisis by encouraging Congress to continue enhancing its health savings account (HSA) program, originally made available in 2003. Three unique elements distinguish an HSA-qualified plan from a traditional insurance policy. First, an HSA-qualified plan generally charges lower premiums and higher deductibles than a traditional plan. Second, it establishes a limit (between \$1,100 and \$5,600 for single-person coverage in 2008) on annual out-of-pocket costs that policyholders will be expected to pay,<sup>13</sup> and “the deductible, co-pays, and co-insurance amounts paid under the plan *must* count toward meeting” this limit.<sup>14</sup> In some HSA-qualified plans, the out-of-pocket maximum is as low as the annual deductible, in which case the policyholder will know ahead of time that he or she will have to finance only the deductible before insurance kicks in to cover 100% of remaining expenses. Finally, an HSA-qualified plan allows policyholders and their employers to invest pre-tax income into a health savings account accruing tax-free compound interest. Funds from this account may be withdrawn tax-free to pay off future qualified medical expenses below the deductible (presumably if the deductible equals the out-of-pocket limit).<sup>15</sup>

The HSA equivalent for Medicare recipients is the MSA, or medical savings account. Without an MSA, a typical senior spends post-tax income on Medicare coverage (including premiums, deductibles, and co-insurance), Medicare supplemental coverage, and prescription drugs. An ideal MSA-qualified plan, on the other hand, would allow that senior to use tax-free income to pay only the deductible, and to invest the saved money into an MSA to cover future deductibles. Such a plan would not only save seniors traditional out-of-pocket expenses, but is also estimated to reduce government expenditures by \$10.7 billion per year.<sup>16</sup>

Unfortunately, the national MSA program contains two major flaws. First, current law prevents seniors from investing their own money into their MSA; instead, the federal

government contributes a sum too small to meet the annual deductible. Second, many insurance companies do not offer MSA-qualified plans due to a regulation imposed by the Centers for Medicare and Medicaid Services (CMS) that MSAs be “risk-adjusted” to allow unhealthy seniors to receive more Medicare funds than healthy ones.<sup>17</sup> While the first rule impedes consumer control, the second obstructs MSA availability. Rooney and Perrin rightly call for elimination of both of these problematic policies.

The third major reform proposed by the authors is increased transparency of medical prices. To prevent hospitals from charging unreasonable rates, the federal government should require each hospital to disclose cost-related information such as its average daily cost per patient, total revenue, and the amount of funds it receives from Medicare. Other hospital figures worth reporting are the real costs of procedures compared to the amounts charged for those procedures, as well as the amounts collected by the hospital from Medicare, managed-care insurers, private insurers, and self-pay patients.<sup>18</sup> Finally, hospitals ought to “give patients estimated charges for all non-emergency care in advance, in the same way we get estimates for car repairs.”<sup>19</sup>

Rooney and Perrin also call upon the CMS to produce a comprehensive listing of Medicare rates in an easy-to-read format. Citing a Florida tribunal court case and Dr. Gerard Anderson of the Johns Hopkins School of Medicine, the authors conclude that a reasonable rate for hospital care is between 120 and 125 percent of the amount Medicare would pay for that care.

Reform number four recommends an additional method for addressing hospital price gouging. Congress ought to condition the tax-exempt status conferred upon nonprofit hospitals upon the reasonableness of the hospitals’ rates charged for care. In this way, the government could hold hospitals to account and prevent them from collecting exorbitant fees.<sup>20</sup>

The fifth reform aims to alleviate the difficulty of high-risk Americans obtaining insurance. Some states have attempted to solve this problem by requiring private insurers to cover all applicants regardless of age or health, a mandate known as “guaranteed issue.” Unsurprisingly, this approach has proven detrimental; by sending the message that insurance is always available, guaranteed issue reduces the demand for coverage, driving insurance prices sky high. In New Jersey, a family can spend as much as \$77,610.98 per year on deductibles in Part D health insurance, thanks to “compassionate” guaranteed issue laws!<sup>21</sup>

A better solution, write Rooney and Perrin, is for each state to maintain a “state risk pool,” which is a federal “government-subsidized health insurance plan for high-risk individuals” who cannot otherwise obtain coverage. Funding for these pools comes from federal subsidies and private insurers within the state, the rationale being that “neither the participants nor the taxpayers are left holding the whole cost.” Unlike guaranteed issue requirements, state risk pools do not spike insurance prices, since only those enrolled in the high-risk plan pay a mere 25% extra for coverage.<sup>22</sup>

A sixth needed change, write Rooney and Perrin, is the opening of health insurance to the free market by abolishing state and federal regulations which permit individuals to purchase only insurance offered in their state of residence.<sup>23</sup> Observed Sally Pipes of the Pacific Research

Institute, “Choice and competition are the great taskmasters that relentlessly deliver lower prices and higher quality to American consumers.”<sup>24</sup> Rather than conceding to powerful insurers who have an interest in restricting available coverage, Congress ought to allow people to comparison shop across state lines to “get the best coverage and the best price.”<sup>25</sup>

In addition to their reform proposals, Rooney and Perrin applaud a new and growing trend that is sure to benefit health care consumers: the inclusion of “quick-care clinics” in retail establishments. These clinics offer a “limited range of basic tests and treatments” — providing vaccinations, diagnostic screenings, physical examinations, and treatment of common sicknesses — under the direction of a qualified physician’s assistant or nurse practitioner. Quick-care clinics charge cheaper rates than regular doctors’ offices and emergency rooms, accept most insurance, and write prescriptions which can be filled at the same location, provided that the clinic is located in a store like CVS or Wal-Mart. Unlike most regular doctor’s offices, quick-care clinics accept walk-ins without appointments, and offer quality care within about fifteen minutes of arrival. Moreover, such a clinic provides a place other than the emergency room to receive non-emergency care.<sup>26</sup>

At the heart of Rooney’s and Perrin’s reform endeavor is an effort to seize managerial control from the state and place it in the hands of the people whose health is at stake. Only two aspects of *America’s Health Care Crisis Solved* hold the potential to raise issues for conservatives. First, Rooney and Perrin are not content merely to compel hospitals to publish their prices. They also want to use the arm of the federal government to punish hospitals which charge rates higher than what the government determines to be “reasonable.”<sup>27</sup> Yet, the first solution is sufficient, since increased transparency of hospital rates would allow for comparison shopping, which would introduce competition, which would force price gougers out of the market. The need to go one step further and establish price controls upon hospitals is completely unnecessary, not to mention opposed to the principles of limited government and free market economics. In the event that the government’s determination of what was “reasonable” actually failed to generate a profit, a price control may have the unintended effect of reducing the number of treatment procedures a hospital is willing to offer.

Second, while Rooney and Perrin dislike government-managed health insurance, they are not necessarily averse to some levels of government-funded — or, more accurately, taxpayer-funded — insurance. For example, the Fair Care benefit offered by the federal government would be a “cash grant,” not a “tax reduction.” Thus, an individual who owes no income taxes could still qualify to receive the credit.<sup>28</sup>

Rooney and Perrin argue that a tax credit is necessary because a mere reduction would be insufficient in helping some low-income earners afford health insurance.<sup>29</sup> Speaking of President Bush’s 2007 proposal to offer tax reductions — not credits — for health coverage, the authors write, “If we see government’s role as to help those who are financially unable to purchase insurance, the president’s proposal doesn’t do enough.”<sup>30</sup> Many would not view such a task as the role of government at all. In fact, any government-sponsored humanitarian program

that is made possible by redistribution of earned income — such as Fair Care or state risk pools — is automatically suspect among many fiscal conservatives.

Three fundamental questions arise from the view that government management is problematic while government subsidization is not. First, do government-funded programs remain free from government control, or does the record indicate that state oversight often follows state dollars? Second, is redistribution of income truly the most effective, efficient, equitable, and stable means of providing coverage to the uninsured? Finally, should government at any level be in the business of providing health insurance?

Regardless of how one answers these questions, one does well to remember that incremental solutions — while not fully satisfactory — are nonetheless realistic, and that half a loaf is better than no loaf at all. Rooney's and Perrin's proposed solutions to the American health care crisis are far superior to what the status quo has to offer. While some of their reforms may contain minor imperfections, virtually all of them constitute a giant step in the direction of an affordable, market-based, consumer-driven approach to health care.

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## Endnotes

<sup>1</sup> J. Patrick Rooney and Dan Perrin, *America's Health Care Crisis Solved: Money-Saving Solutions, Coverage for Everyone* (Hoboken, NJ: John Wiley & Sons, Inc., 2008), 4.

<sup>2</sup> *Ibid.* xviii, 4-7.

<sup>3</sup> *Ibid.* 5.

<sup>4</sup> *Ibid.* 10.

<sup>5</sup> *Ibid.* 11-13, 23-24.

<sup>6</sup> *Ibid.* 27-38.

<sup>7</sup> *Ibid.* 131-134.

<sup>8</sup> *Ibid.* 133, authors' emphasis.

<sup>9</sup> *Ibid.* xiii.

<sup>10</sup> *Ibid.* 43-44, 46.

<sup>11</sup> *Ibid.* 46.

<sup>12</sup> *Ibid.* 45, 47.

<sup>13</sup> *Ibid.* 74, 185.

<sup>14</sup> *Ibid.* 185, authors' emphasis.

<sup>15</sup> *Ibid.* 69-70, 80-81, 186, 192, 194, 198.

<sup>16</sup> *Ibid.* 53-54, 56-60.

<sup>17</sup> *Ibid.* 55-56, 85.

<sup>18</sup> *Ibid.* 103, 105-107.

<sup>19</sup> *Ibid.* 106.

<sup>20</sup> *Ibid.* 12-13, 135-136.

<sup>21</sup> *Ibid.* 109, 113-114.

<sup>22</sup> *Ibid.* 115.

<sup>23</sup> *Ibid.* 114, 121-122, 124.

<sup>24</sup> Council for Affordable Health Insurance, "72% of Americans Want Health Insurance Choice," press release, 30 September 2004, quoted in J. Patrick Rooney and Dan Perrin, *America's Health Care Crisis Solved: Money-Saving Solutions, Coverage for Everyone* (Hoboken, NJ: John Wiley & Sons, Inc., 2008), 124.

<sup>25</sup> J. Patrick Rooney and Dan Perrin, *America's Health Care Crisis Solved: Money-Saving Solutions, Coverage for Everyone* (Hoboken, NJ: John Wiley & Sons, Inc., 2008), 122-123.

<sup>26</sup> *Ibid.* 127-130.

<sup>27</sup> *Ibid.* 12-13, 106, 135.

<sup>28</sup> *Ibid.* 45, 135.

<sup>29</sup> *Ibid.* 48-49.

<sup>30</sup> *Ibid.* 49.