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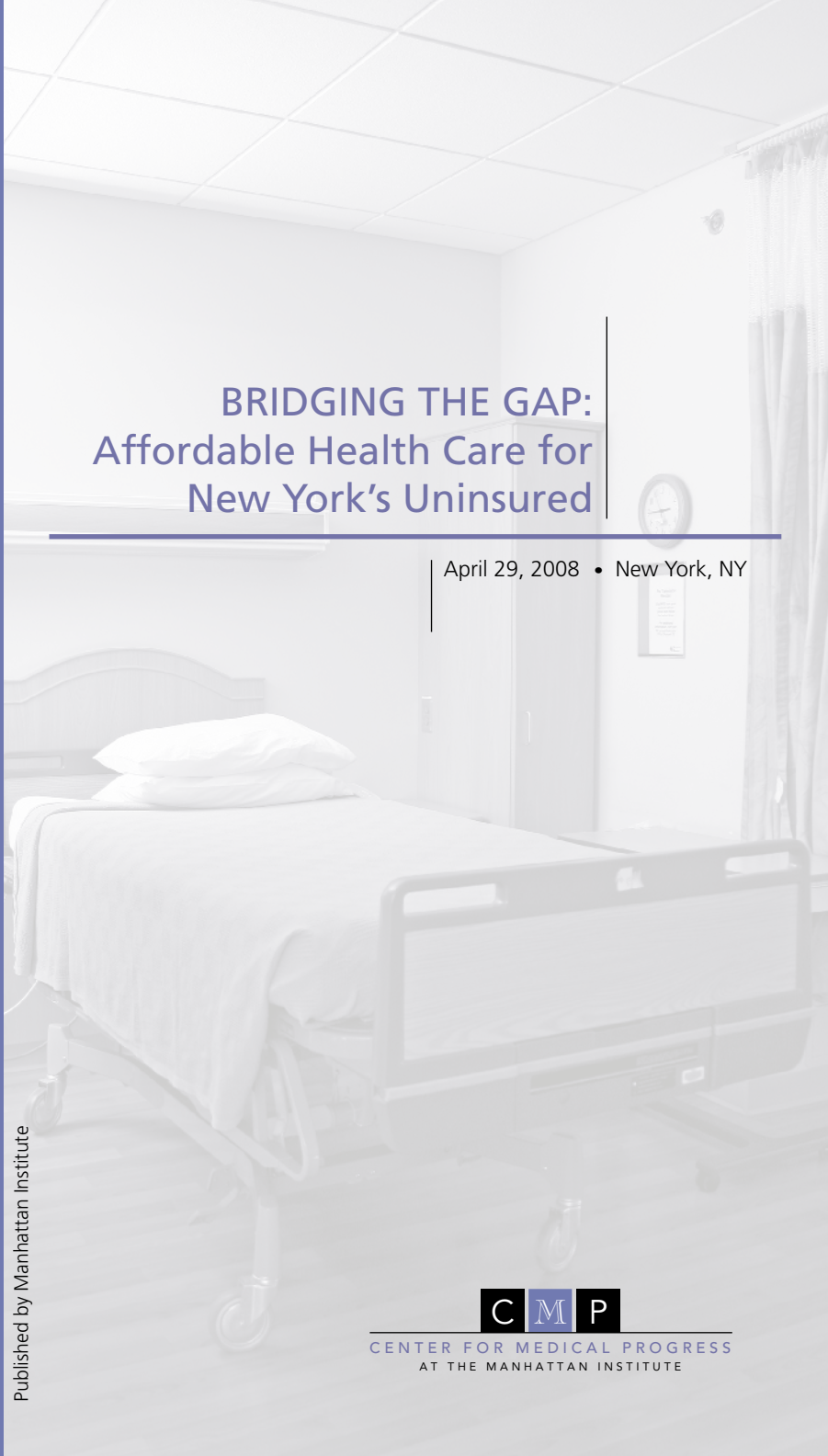

BRIDGING THE GAP: Affordable Health Care for New York's Uninsured

April 29, 2008 • New York, NY

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AT THE MANHATTAN INSTITUTE

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INTRODUCTION

PAUL HOWARD: I am a senior fellow and the director of the Manhattan Institute's Center for Medical Progress. I'd like to welcome everyone here, on behalf of the Manhattan Institute and our cosponsor, the New York State Health Foundation. The Center for Medical Progress encourages the development of market-based public policies to promote medical innovations and improve public health. We are proud members of the New York State Health Foundation's Coverage Consortium, which is dedicated to expanding access to more affordable insurance options for New York's uninsured. As our own Tarren Bragdon has pointed out in his "Rx NY" report, it is critical that we have a healthy, well-functioning private-insurance market to ensure that scarce public dollars are reserved for providing health-care assistance to our poorest and sickest citizens. But in maximizing help for the needy, we must also be cautious

that regulation of private-insurance markets does not exacerbate the problem of the uninsured.

Our first panel will examine how state regulation of insurance markets affects the affordability of insurance, and the panel will suggest innovative ways to make New York's individual direct-pay market more responsive to the needs of today's workforce, including the young, relatively healthy consumers who may find themselves switching jobs frequently and thus poorly served by traditional, employer-based insurance options.

Our second panel will focus on the entrepreneurial companies and physicians who are changing the ways that patients interact with the health-care system. Physicians are opting out of traditional insurance arrangements while creating new formats that promote a true medical home. Convenient-care clinics are springing up in retail outlets that offer rapid access to routine and preventive care, complementing the primary-care system and, one hopes, reducing the strain on our overburdened emergency rooms. We have heard a lot over the last month, particularly from the Dartmouth Atlas of Health Care, on pricing disparities in the treatment of chronically ill patients, even among America's best hospitals. Today, we'll hear how some companies are finding ways to arbitrage these prices and quality differences in order to lower health-care costs and improve patient care. Our second panel will conclude by looking at how one state, Georgia, is trying to cover more of the uninsured by leveraging market forces.

Our keynote speaker is noted Harvard Business School professor and Manhattan Institute senior fellow Regina Herzlinger, who will offer her reflections on how to unleash innovation in health-care markets. Regina has recently written a book titled *Who Killed Health Care?*—and I think that her answer is that we have all had a hand in the death. The first thing I think that she'll ask us to do is to stop making decisions for patients and to empower them to make their own choices. But I'll let her explain how she sees that happening.

Before we start, I'd like to introduce Jim Knickman, the CEO of the New York State Health Foundation, whose support has been critical to our participation in the Coverage Consortium. Dr. Knickman is the first president and CEO of the New York State Health Foundation, and he comes to the foundation with tremendous experience and expertise in public health and health-care analysis. Prior to join-

ing the foundation, Dr. Knickman was vice president of research and evaluation at the Robert Wood Johnson Foundation, where he was responsible for external evaluations of national initiatives. Throughout his fourteen-year tenure at Robert Wood Johnson, he also led grant-making teams in the areas of clinical care for chronically ill, long-term-care services and population health. He is coauthor of a widely used textbook on health policy and management, serves as chairman of the Robert Wood Johnson Health System, and is a member of the editorial boards of the *Milbank Quarterly* and *Inquiry*.

In my experience working with Jim on the Coverage Consortium, he's an exemplar of what we need in our health-care debates today: someone who asks tough, smart questions and is supportive of good policy ideas no matter what partisan label happens to be attached to them. Please join me in welcoming Dr. James Knickman.

JAMES KNICKMAN: Recently, I felt very proud when I was asked to be part of a panel explaining the candidates' health-care reform positions—because after I finished speaking, someone commented, "I don't think I've ever heard anybody talk about this stuff, and I can't figure out which side you're on." And I replied, "Good! That means that I was successful." I think it's important that we look at health-care reform in a broad way.

Why is health care such a complicated issue to get right? I think it's because four factors come together in a baffling way: insurance coverage; access to care; cost of care; and quality of care—and figuring out how to pay for it. In our society, it is very hard to get those four things working together in a way that doesn't squeeze the balloon in the wrong direction if you work on one versus the other. Too often, we work on these issues in isolation—people working on coverage, people working on access, people working on cost, people working on quality. But they're all one problem. If we expand insurance coverage, but costs go out of control, it's going to fall apart because we're not going to be able to afford that insurance coverage. That is what has happened in some of the other states that have made important first steps. If we improve quality but it's unaffordable, we don't have access.

So trying to get these four issues right is important. There are other complicating and interacting factors as well: markets and government. We must figure out how to bring those two forces together.

It's easy when you have an economic good that can totally rely on the market, which determines supply/demand or price. It's also easy when you have an economic good that comes totally within the realm of government. But in health care, we need to bring markets and government together. It's hard to do that because while we may have a basic health-care package of services, it can be so expensive that 30–40 percent of Americans cannot afford it. So we must have some government role. Americans are quite committed to using markets, too. Trying to put those factors together really challenges us.

Our foundation came out of the Empire–Blue Cross conversion, and we're here to improve the health of New Yorkers and to make a better health-care system and better public health system. We think that expanding insurance coverage is crucial. Insurance coverage is in our mission statement. For over two years, in our efforts to do something about coverage, we have made four big bets.

First, we developed the Coverage Consortium, which analyzes the choices for us to make as a state about how to expand insurance coverage. The consortium includes the Manhattan Institute in addition to the Community Service Society, New Yorkers for Accessible Health Coverage, United Hospital Fund, the Rockefeller Institute, and Columbia and Cornell Universities.

The second bet is a Medicaid initiative. Almost a million people who are eligible for Medicaid are not enrolled. We have to figure out how to make it easier for those people to get enrolled and to stay enrolled. So we're doing administrative studies and other work to figure out how to get coverage for the people who are actually eligible.

Our third bet is in a small-group market. Many of the working people who are uninsured are in this market. It has been a big challenge to figure out how to get small-business owners to focus on insurance coverage. If you want to grapple with this problem, you have to grapple with the small-coverage market.

Our fourth bet on the coverage side is cost. Unless you worry about cost and affordability, the focus on coverage is not really worth it.

PANEL I: REVITALIZING THE INDIVIDUAL (DIRECT PAY) INSURANCE MARKET IN NEW YORK

TARREN BRAGDON: I am an adjunct fellow at the Center for Medical Progress. I have the pleasure of moderating this panel, where we're talking about revitalizing the individual direct-pay market in New York. Before we hear from our esteemed panelists, I want to provide some perspective on New York's direct-pay market.

For over fifteen years, New York has had one of the most highly regulated, uncompetitive, and expensive individual-insurance markets in the country. In the early 1990s, 750,000 people were covered in this market. Today, fewer than 100,000 are covered. Premiums in the direct-pay market begin at over $500 per month for individual coverage. By comparison, California, which has a very competitive individual market, with almost twice the population of New York State, covers 2.8 million people in its individual market, according to its Department of Insurance.

In New York, there are 2.2 million uninsured adults. Over half of them are young adults, aged 18 to 35. A third are aged 35 to 49, and the remaining ones are near-retirees. Almost a third are noncitizens, a situation that is [unusual], compared with many other states. Some 90 percent report that they are in good health. Two-thirds have no dependent children at home, and 69 percent of New York's uninsured adults are single. Their household budgets and the types of coverage that they might be looking for are likely very different from those of someone with financial obligations beyond just himself. Sixty-one percent of New York's uninsured adults earn over $25,000 a year, and a third have household incomes of over $50,000 a year. If we use the Swiss standard of affordability—highlighted in Regina Herzlinger's writings—of 10 percent of family income, the vast majority of New York's uninsured would be looking for out-of-pocket premiums of $200 a month or less.

We know from national studies that the majority of uninsured are temporarily uninsured. Seven out of every ten people who become uninsured become reinsured within a year.

In summary, New York's uninsured population, for the most part, is young, childless, and healthy. It is an attractive population to insure through the individual market. It is also a very mobile population.

We know from research by RAND on California's individual insurance market that, when presented with an opportunity to buy affordable coverage, individuals who don't have access to coverage through their workplace will buy coverage. According to this RAND study, three out of ten who don't have access to work-based coverage and are over the age of thirty-five will voluntarily buy coverage; that take-up rate does not significantly increase with subsidies provided by the government and is not projected to increase with subsidies. We also know that four out of ten of the nonpoor uninsured will voluntarily buy coverage.

For us, a revitalized direct-pay insurance market in New York would be an important [contribution] to maximizing the number of people with private health-insurance coverage so that we can reserve scarce public dollars for those who are truly poor and uninsured.

Our first presenter is David Hyman, the Richard and Marie Corman Professor of Law as well as a professor of medicine at the University of Illinois.

DAVID HYMAN: Insurance theorists talk about insurance, regardless of the type of insurance, as serving three distinct functions: risk-shifting from the insured to the insurer; risk-spreading through the insurer to the broader pool; and risk distribution, by charging different premiums based on risk. You basically socialize the risk across the pool and decrease the variance of the risk. Many risks are binary: you're either hit by a hurricane or you're not. The overall probability of that is somewhere between zero and one. But you don't know whether you're at zero or one, and you're willing to buy insurance to reduce to a fixed amount the associated risks and move away from the zero-one, binary set of choices.

Insurance allows for risk distribution. We charge different premiums to people based on the element of risk that they are transferring. So the paradigm case for insurance is a very low probability of a really bad outcome, such as getting wiped out by a tornado. And the more you move away from that paradigmatic case, the less you're dealing with insurance and the more you are prepaying expected cost. Group versus individual coverage is a very important distinction; I'll have more to say about that shortly.

We're going to be talking mostly about individual insurance. Each arrangement has its own advantages and disadvantages. Group

coverage is cheaper to underwrite, partly because you don't have to deal as much with adverse selection because it's a prepacked socialization of risk. On the other hand, if you're the person who is bundled in with people whose risks are higher than yours, you end up having to foot the bill for their risks, rather than your own. Individual insurance, at least in theory, has a more tailored distribution of risk profiles, but it's significantly more expensive to write. The last point is the basic regulatory framework that applies to group versus individual insurance. Individual insurance has a fairly significant risk-pooling function built in. Group insurance has its own elements of risk distribution. So keep in mind that reality is messy, and theory is neat.

Here are some facts about where Americans nationwide get their health insurance, based on 2006 census numbers. Private coverage covers about 68 percent of the market. Employer-based coverage is responsible for about 176 million individuals in self-funded and insured plans. Individual insurance is about 27 million people, or 9 percent of the population in the U.S. Public coverage is 80 million, or about 27 percent of the population. The uninsured are 47 million, or about 15 percent of the population. That number has been going up steadily while the number of people receiving private coverage has been going down fairly steadily, although it has stabilized in the employer-based side of the market at about 60 percent.

The first key difference between employment-based insurance and individual insurance is obviously that the former is group-based coverage and the latter is individual. Whether you can get employment-based insurance varies greatly, depending upon who your employer is, what sector of the economy your employer is in, and whether you have a large employer. There are certain areas of the economy where it's relatively unlikely that you'll have the opportunity to purchase insurance from your employer. If you work in the retail or agricultural sectors, the probabilities are significantly lower than they would be in other sectors of the economy. Size also matters: the larger your employer, the more likely that you will be able to obtain employer-based health insurance and the more likely that you will have a choice of insurers.

Another important distinction between employer-based and individual insurance is the tax subsidy. If you obtain insurance through your place of employment because of some idiosyncrasies of the tax

law, you basically can purchase it with pretax dollars. People who buy individual insurance have to buy with after-tax dollars. Because we have a progressive tax system, that's worth more to people in higher-income brackets.

ERISA, under some circumstances, effectively preempts all relative state regulations if you're a self-funded ERISA plan. About 55 percent of the employment-based health-insurance market is in self-funded ERISA plans. There are limitations on the [right to file a claim] against the plan for coverage decisions. Private coverage is regulated primarily at the state level, which means that it varies tremendously. The states vary tremendously in how aggressively they regulate insurance. There is limited federal regulation.

ERISA is perhaps the last major piece of legislation that affects health insurance. A series of focused federal mandates includes: the Health Insurance Portability and Accountability Act (HIPPA), which imposed portability requirements; the Mental Health Parity Act; and the Newborn and Mothers Health Protection Act, which guaranteed coverage of forty-eight hours postpartum for vaginal delivery and ninety-six hours for a C-section.

A conceptual model for thinking about these regulations includes three basic relationships: insurer-physician, physician-patient, and patient-insurer. We have three different types of regulations. As I said, states have regulated fairly aggressively here. The mean number of mandates per state is about thirty-six. They primarily regulate the insurer-physician and the patient-insurer relationship. The states generally have not tried to regulate aggressively the physician-patient relationship, with forced disclosure arrangements.

It's important to recognize that states also impose premium taxes—that's the source of a significant amount of revenue for the states. Each state has a regulatory monopoly over the terms of coverage that can be sold to its citizens, except that ERISA creates a very large loophole if your employer is self-funded. Self-funded employers don't pay state premium taxes and are not subject to any of the regulatory mandates, including community rating, guaranteed-issue, and coverage of specific benefits.

New York has about 13.2 percent uninsured, with a margin of error of plus or minus five. That's compared with about 15.2 percent nationwide, so it is slightly below average. That's a good thing, but

it is above average in the number of mandates it imposes: fifty-two versus thirty-six, including community rating and guaranteed-issue, in the small-group market. You've already heard about that from Tarren and Paul. Apparently, there is concern about the number of mandates and their impact on health-care quality and cost containment.

The good news is that a state commission was established to examine these and other issues. The bad news is that no one has yet been named to the commission, and it has not yet met. More bad news: the cost of care in New York—whether you look at the volume of care or the cost per unit—is higher than average, and the quality is nothing to brag about.

The point that I want to end with goes back to the idea of social insurance versus risk-based insurance, and private insurers versus public insurers. No matter how you regulate private insurers, you are not going to turn them into public insurers. If you want public insurance, you should enact it. Trying to get private insurers to behave like public insurers is not, in the long run, a particularly effective strategy. And it doesn't provide any benefits for its intended beneficiary: the consumers whom we all care about.

Trying to get private insurers to behave like public insurers is not, in the long run, a particularly effective strategy. And it doesn't provide any benefits for its intended beneficiary: the consumers whom we all care about.

TARREN BRAGDON: Next we will hear from Sherry Glied, chair of the Department of Health Policy and Management at the Mailman School of Public Health at Columbia University.

SHERRY GLIED: I do most of my work on group health insurance, so when I had the task of talking about the individual market today, I had to do some research. The first conclusion I came to is that we need to have a functioning non-group health-insurance market if we're going maintain the system of private health insurance because there is a group of people who naturally should be getting coverage in the non-group market. These are people who live in families that

can afford coverage—they don't need to be in public programs—but they are either self-employed or work in tiny firms that don't have much of a pooling advantage; or they aren't working, or they are in the short-term or contingent work market. That group probably constitutes 20–25 percent of the population under the age of sixty-five, which is quite a big market, although clearly the smaller part of the private-insurance market.

Two problems face non-group insurance markets. The first is that expenditures on health care are very highly skewed. One percent of people in any population account for 25–30 percent of health-care expenditures in a year, and 50 percent of people in any health-insurance market account for only about 3 percent. That a very small number of people account for most of the cost affects the way that many insurance markets work. The difference in the health-insurance market is that much of the information that would enable us to predict whether you're in that category of very expensive people is known by people who would be buying insurance but cannot be known by insurance companies.

I'm struck by studies that look at everything you can find out about a person's health status, everything that can be gotten from his or her health record, everything that can possibly be given to an insurance company. Then you ask a person, "How do you rate your own health on a five-point scale: excellent, very good, good, fair, or poor?" It turns out that a person's rating of his own health has a huge predictive value in telling us whether he is going to have high expenditures next year. Much private information exists in this market. That is very problematic because it means that people have the opportunity to select their health plan, to decide to participate in the market, to retain coverage or drop coverage, and to choose what kind of coverage they want, all based on private information. Insurance companies naturally have to respond to the fact that all this private information exists. So private information is one big problem that exists in non-group insurance markets.

The second problem, which is not recognized enough in the non-group health-insurance market, is that health-insurance markets are worse than other kinds of insurance markets because they don't pay off in cash. The contract pays off in services, which means that the payoff is not fungible. In a life-insurance market, or even an auto-

mobile insurance market, you could layer coverage or you could sell away coverage, in effect, over time. The health-insurance market is inherently less flexible. The rewards of the health-insurance contract are not fungible. That has one serious consequence. People want long-term health-care protection. They don't want health insurance for one year; they want health insurance forever. It's essentially impossible to sell lifetime health-insurance contracts to non-group health-insurance markets; they pay off in services. This market is fundamentally flawed, but we need to have it working.

All these flaws in the market have created a golden opportunity for regulators to mess up the market even more. They have generated regulatory capture. But I'm going to argue that these regulations don't matter so much. The regulations are a mess but they don't make much difference to the functioning of the market.

Probably the number-one thing that people worry about concerning these markets is costly mandated benefits. According to the Council for Affordable Health Insurance, in the state that has the most mandated benefits—Maryland—the benefits add about 40 percent to the cost of the health-insurance package. In the cheapest state, which I think is Wyoming, the benefits add only about 4 percent to the health-insurance package. There is a big difference in the scope of mandated benefits among states.

Economists say that mandates make sense in some situations. Whether that is true or not, mandates don't matter as much as we suspected they would. To demonstrate this, I compare coverage in big and small firms. Firms with more than a thousand employees have ERISA plans. They are exempt from all these state-mandated benefits, and they do whatever they like. Overall, about 68 percent of people who work in very large firms get coverage from their own employer. So let's compare coverage in these firms with coverage in firms that are strongly affected by mandated benefits: small firms that have no more than twenty-five workers.

On average, about 30 percent of employees in those small firms get coverage from their employers collectively. When you compare coverage in very big and small firms across states, you see that in states where many people in big firms get coverage from their own employer, many people in small firms also get coverage from their own employer. There is a strong correlation between what

happens in the non-mandated ERISA market and what happens in the mandate-affected non-group and small-group markets, probably because of similarities in the underlying demand for coverage and price of care.

What happens in states with many mandated benefits? Consider New York, a state in which about 71 percent of people who work in large firms get coverage and about 34 percent of people who work in small firms get coverage. That is similar to the national average. The rate for small-firm coverage is only slightly lower than it is in states with comparable rates of large-firm coverage and few benefits. In general, states with mandates don't stand out at all. Maryland is the state with the highest mandated benefits in the country. It also has an unusually high rate of small-group health-insurance coverage.

States with very few mandate benefits don't perform consistently better. Mandated benefits seem to cost a lot, but the insurance market seems to have figured out how to deal with them. They are not affecting coverage rates as much as we would expect them to. They just don't seem to matter.

Can eliminating rating restrictions fix this market? Not much. The literature on rating restrictions—there is much economic and empirical writing on this—says that rating restrictions shift the composition of health-insurance markets. They lead older and sicker people to be in the market, and they lead younger, healthier people to be out of the market. As Tarren said, there are many young and healthy people who are shut out of the market because of rating restrictions. The flip side is that some older, sicker people are in the market because of these same restrictions. The restrictions have some effect at the aggregate level, reducing non-group coverage about 2 to 3 percent.

The potential market for non-group health insurance is self-employed people or people working in small firms. Some states—such as Montana, Wyoming, South Dakota, and North Dakota—have many people with non-group insurance. But that's because those states have many farmers and many self-employed people who have to be in that non-group market. In states such as New York and California, fewer people naturally belong in the non-group market. New York, which has community rating, does a little worse than a place like California. Eliminating community rating would increase non-group coverage

in New York. If we eliminated community rating, though, we would introduce many new problems in the non-group market because we would shift the sick people out of what is now a protected market. We need to think about how to do that.

Can better subsidies fix this market? Like Tarren, I think not. The price elasticity of demand for health insurance in the non-group market is quite low, especially for inexpensive products. There have been major expansions in the tax-deductibility of health insurance in the 1990s, in the HSA system—and what has happened at the aggregate level? Between 1995 and 2003, we expanded the tax-deductibility for the self-employed from 25 percent to 100 percent. In 1997, eHealthInsurance was founded, which was important in bringing down administrative costs. In 2004, we instituted HSA regulations. But [despite] all these changes facing non-group coverage, the percentage of people in the non-group market remained virtually unchanged. We introduced major new subsidies in the non-group market over the 1990s, and it made no difference.

Remember that there are huge subsidies in the group market, so we need to level the playing field in some way. The evidence today suggests that probably the best way to achieve those subsidies is through reinsurance money, not tax credits.

What to do? Start off with what *not* to do. The non-group market is the residual market; it is not the main market. It would be a disaster to mess with the ERISA plans in order to fix the non-group market. Second, more competition is not, by itself, going to fix this market, although it might lead to somewhat lower administrative costs. We need to do more than that. Third, community rating is costly, but suddenly getting rid of it will create a major upheaval, so we need to think about how to do that.

We do need subsidies in this market. Remember that there are huge subsidies in the group market, so we need to level the playing field in some way. The evidence today suggests that probably the best way to achieve those subsidies is through reinsurance money, not tax credits. Reinsurance would be particularly useful if we were

going to get rid of community rating because it would soak up some of the variation at the high end of the market.

TARREN BRAGDON: Next we'll hear from Gary Lauer, president and CEO of eHealthInsurance.

GARY LAUER: We formed eHealthInsurance in 1997. We market and sell health insurance online as an Internet-based company. We focus primarily on the individual markets, for people buying individual products, and small groups that typically have fewer than fifty employees. In the spirit of full disclosure, I should say that we are a profit-making company and a publicly traded company on NASDAQ. So you can certainly argue we have an economic interest in this market and in this business. The majority of the business that we do is for individuals—people who, for many reasons, buy their own health insurance.

Several years ago, I spoke at a meeting in Washington, D.C., along with a number of members of Congress. At that time, a great deal of opinion and emotion surrounded this topic but very little fact. It seemed then that what we ought to try to do, because we had a treasure trove of information in our company about people buying health insurance, is mine some of those figures and produce something that explains what is occurring in the markets. So every year since then, we have published an annual "Cost and Benefits of Health Insurance Plans" survey. We survey our member base or customer base to ascertain what people are paying for health insurance and what kind of benefits they are receiving.

We market and sell health insurance in all fifty states, and, as you have already heard, it is a highly regulated business, regulated state by state. We are licensed in all fifty states. We do not underwrite health insurance. We are not a health-insurance company. Rather, we are a distributor or broker, so we represent the major carriers—Aetna, United, GSI, Oxford in New York, and so on.

You might be interested in taking a look at "The Costs and Benefits of Individual Insurance Plans: 2007," available at www.ehealth.com. We helped publish this with Forrester Research. We've also done this in the past with the Kaiser Family Foundation. This report surveys about 160,000 individual and family policies purchased

through eHealthInsurance. We've taken a look at how much people are paying for health insurance and which benefits are being provided. We give you information about age and gender. We also break this out by families, although I'll comment on individuals for now. It is interesting to see how this business looks state by state. On average, health insurance for an individual in Iowa is about $98 per month. Health insurance in New York, the most costly in all fifty states, averages about $358 per month, more than three times what people pay in Iowa. The average across the United States is about $140 a month. New York, among four other states, is a guaranteed-issue state, which simply means that no one can be denied for any reason. The theory makes a lot of sense, but in practice, it forces these products for various reasons to become very expensive—in many cases, prohibitively expensive—which leaves many people out.

On average, health insurance for an individual in Iowa is about $98 per month. Health insurance in New York, the most costly in all fifty states, averages about $358 per month, more than three times what people pay in Iowa. The average across the United States is about $140 a month.

If nothing else, look at page fourteen, because it lists all fifty states broken out by what people pay on average for health insurance in the individual market, what their average ages are, and the kind of benefits that they receive. These are fairly robust products and typically have physician benefits for physician co-pay, pharmaceutical co-pay, and, in many cases, maternity benefits. The states that are guaranteed-issue and/or community-rating are Maine, Massachusetts, New Jersey, New York, and Vermont. Kentucky, New Hampshire, and Washington were, but have since either modified or repealed these mandates.

We have had an interesting experience in Washington State. In 1993, at about the time the Clinton administration was pushing hard for change in the health-care landscape, Washington's state legislature took on many principles that the administration was discussing and designed a plan that reflected them. In fact, the legislature was

open about the fact that it had modeled its plan after what was being discussed in Washington: guaranteed-issue, community rating, mandates—one mandate being that everyone had to buy health insurance along with a number of other things.

In the first two years, the number of health-insurance carriers providing health insurance in the state quickly declined, because a business cannot be forced to do business. They chose not to participate in the market, so the choice of products declined. Second, the ranks of the uninsured increased in the first twelve months—by over 20 percent. Third, the price of these products increased 40–50 percent.

Later in the 1990s, there were small changes. In 2000, the state legislature got together and repealed the guaranteed-issue part of this health-care reform. We came into the market with several large carriers that had not been there previously. Prices fell, interestingly. Washington is one of the few states in the country, over the last seven years, where the rates have not increased—they have actually stayed flat. You'd like to think they went down, but, given the trend of increasing premiums in other states, staying flat is actually a good thing.

In California, my home state, Governor Schwarzenegger—a Republican governor in a Democrat-dominated state legislature—in his State of the State Address, in January 2000, proposed sweeping changes to health care in California and the landscape called the California Health Care Reform Act. I was quite involved with the governor's staff and spoke with the governor many times. California is very much an open-market state. It's a vibrant market with many products to choose from, and a large percentage of people in this market buy individual health-insurance and small-business products.

The governor's plan was to put a guaranteed-issue mandate or regulation in place to mandate that everyone buy health insurance as well as a number of other things. At first, it was applauded. In January 2008, it was crushed—that's probably the right word to use in the state legislature—by Republicans as well as Democrats for a couple of reasons. One was that many characteristics of guaranteed-issue seemed so appealing but were not quite so appealing to the electorate.

Another reason was that the cost associated with these things became staggering. We have a large deficit in California; the cost of this plan in the first year was going to be about two times

the deficit that the state was already running, so it simply wasn't affordable. In heavily regulated states with lots of mandates, especially guaranteed-issue, these become very expensive plans and programs to administer. So [while there are] the moral reasons for trying to get everyone covered, there are important economic reasons that have to be considered as well.

We have some real issues facing us, not just in the state of New York but in our country as well, regarding the number of uninsured people. More than 47 million Americans have no health insurance. We have a moral obligation to address this problem. But we have an economic issue here as well, along with an economic reason to address it. This is not a problem that is going to stay the way it is; it is growing every day. The number of businesses offering health benefits to employees has been declining for the last several years. A recent Kaiser Family Foundation study noted that in 2000, the number of U.S. businesses offering health benefits to employees was 69 percent, but by 2007 it was down to 60 percent.

Where are these people going for health insurance? They're either buying individual products or joining the ranks of the uninsured. In 2006, the ranks of the uninsured swelled by more than 2 million. The Kaiser Family Foundation also noted that for every percentage point that unemployment rises in our country, more than a million people will join the ranks of the uninsured. This is one more reason for us to think about these markets, mandates, and regulations, and to find sensible, affordable ways for people to get coverage.

TARREN BRAGDON: Last, we'll hear from Sara Horowitz, founder and executive director of Working Today, which offers health insurance to freelance workers.

SARA HOROWITZ: I'm going to talk to you about Mary Jo, a self-employed graphic artist. Mary Jo decides that she's going to get health insurance. She telephones XYZ Insurance Company and buys an individual health-insurance plan. Then Mary Jo has a medical problem—nothing significant—and goes to the doctor, who takes care of it. She then finds that the condition that she was quite sure was covered has been denied by the insurance company. So she telephones the insurance company and says, "You made at terrible mistake. This

isn't the way it should be." The 1-800-XYZ Company asks Mary Jo to send in all the material again. After a week or two, Mary Jo calls the insurance department and says, "I'm Mary Jo, I'm an individual, I bought health insurance, and my health insurance should cover it." They say, "Yes, that's a problem. You should probably send us a letter." So that is Mary Jo in the individual market.

Now I'd like to suggest that this Mary Jo is in the Freelancers Union. Mary Jo calls us up with a problem. We start realizing that not only does Mary Jo have a problem, but ten other people just called us and e-mailed us because they are having the same kind of problem.

This could be one of two kinds of problems: either the error was in the infrastructure, which can easily be worked out; or there is a real misinterpretation of the plan. We believe that we negotiated coverage of the condition, but the insurance company said that we did not. We don't call 1-800-XYZ Company; we call our key person at that insurance company. We have 17,000 people covered in New York. We switched from HIP to Empire, but for both companies, we are one of the biggest contracts because we have 17,000 people. I can assure you that when we hear of Mary Jo's concerns, it's a top priority for us. We are going to get to the bottom of Mary Jo's problem. Either Mary Jo is wrong or the insurance company is wrong or there is a problem that has to be fixed.

We are making a fundamental mistake if we think that Mary Jo is going to do well in the individual market. We have to reframe this debate. Human beings are not cars. When you buy insurance for your car, the kind of driver you are is relevant. But as my father would say, only the lucky ones grow old. We can anticipate that we are going to have illnesses, and we must consider how to start risk-sharing. How should we spread this risk around? Calling people who are under thirty a "group" will not work.

I would like to review our experiences in New York and demonstrate that when you get vertical groupings of people—by profession, skill, chamber of commerce—you will do far better than you would by pulling out your best risks. There has been a change in the economy. People used to work for a large employer, such as a university, factory, or hospital, and the people who had jobs were full-time employees. They had health insurance, a pension, training, and the right to unionize. In effect, the safety net was attached to

the two conditions of having a job and having the legal status of an employee.

But in this new economy, work is short-term and flexible—and the safety net is outdated. Now there tend to be more independent contractors, freelancers, consultants, and self-employed people, and they work more. When they're employees in the short term, they are part-time and temporary. The whole New Deal safety net is not attaching to this part of the workforce, which may not feel like a bad thing at the Manhattan Institute. But we have to agree that we don't have the coherent system for these things that we used to have.

We founded the Freelancers Union to group people together in a market-oriented way. We are completely independent, we are able to exist within the market, and we receive no subsidies.

The Freelancers Union created our 501 (c) (4) status, and Working Today is our 501 (c) (3). We are a platform or online vehicle by which people can come together and purchase insurance, get jobs and education, and talk about new ways that we can come together to purchase these kinds of things as a group.

We are 72,000 nationwide. The states with the most members are New York, New Jersey, California, Pennsylvania, Connecticut, Florida, Texas, Georgia, Illinois, and Massachusetts. In New York, we've been able to group people together. Now, we have to expand to states where there is an individual market.

We founded the Freelancers Union to group people together in a market-oriented way. We are completely independent, we are able to exist within the market, and we receive no subsidies. We are an example of something that works. We have gone to other states with our strategy, and the insurance experts there say that eighteen- to twenty-four-year-olds can get better rates than what we will offer. When state insurance regulations allow the young and healthy to pull out of insurance risk pools, it becomes very difficult to pursue the grouping strategy. The whole point of insurance is to pool together different types of people, with different risk profiles, to create a sustainable grouping. But in those states where young adults take themselves out of the insurance

market, the insurance companies become uninterested in forming large groups for insurance purposes. What results is a bifurcated market in which only large employers can form insurance groups and everyone else is left to face the individual market.

As we look toward the future, we must decide whether we want individuals to be treated like cars or whether we can be creative in our market approaches. We have to be careful about how we group people together. The Freelancers Union is building the next model, for the next New Deal—by grouping people to have power in markets and power in the policy debate so that they can start talking about how individuals can come together in mutual aid and negotiate better rates in the market.

Jim Knickman said that sometimes you can't tell which side someone is on. I think that the next change will be that the same sides no longer exist; it's actually far more complicated. I'm interested in promoting market solutions, but those markets are not going to have the 18 to 30 percent returns that are driving private equity as we're merging insurance companies. When we look at the economic alignments that we are creating now, we have to conclude that the insurance industry is not going be able to make its profit in such a short-term way and that it will instead have to pay back that capital. The insurance industry also isn't going to be allowed to promise such high returns to shareholders that they are required to cherry-pick.

Mary Jo needs to find a group; that group has to be a player in the market; and that group has to be able to capitalize with market money but produce returns of 8 to 12 percent. The only way we can achieve that is by thinking of the tax code as a vehicle by which we can make a market function—not as an auto-industry market but as a civilized market for health insurance that we can be proud of.

TARREN BRAGDON: I'm going to ask two questions of each panelist. First, in your research into several states, or in your experience particularly in states that have competitive offerings and affordable plans, why don't individuals purchase coverage when they have access to it? Second, how much societal benefit do you think there would be in requiring people who do not voluntarily purchase coverage to purchase it?

DAVID HYMAN: Why don't people buy coverage who have access to it? Many people have considered this question and have generally

drawn simpler conclusions. There are two distinct categories: people who simply can't afford it; and people who don't perceive a need for it—the "young immortals," my children among them. They have insurance because I buy it for them, not because they would if I gave them the cash and they got to decide what to do with it. It's related to larger issues of the value of coverage, perceived and actual. Geographical variations enter into this as well.

On the issue of requiring purchase, Massachusetts is taking a crack at this, and the numbers are evolving. Requiring people to purchase involves two separate issues: the first is whether you're doing it because you want to get the low-risk end of the pool in order to subsidize the higher-cost risks; the second involves some moral theory that [prevents] you from saying no to them when they show up at the E.R., so you're going to force them to fund it at the front end. There are other variances, but those are the two ways that I'd explain what's going on.

GARY LAUER: I'll give you my practical experience of why people don't buy coverage. Some people can't afford it. Some people apply for health insurance but don't qualify because they are not healthy. Across the industry, an estimated 15 percent of applicants in the individual business, in a non-guaranteed-issue market, are simply denied. Many people don't know that the market exists; or they perceive that health insurance is prohibitively expensive and that only large corporations can afford to provide it for their employees. Some younger people think that they don't need to have health insurance because they are not going to need it. There is yet another group of people who know that that they need it but also know that they can go to an emergency room—especially in a nonprofit hospital—and receive the care that they need.

Our approach has been to address each issue incrementally as we look at the ranks of the uninsured or why people don't purchase health insurance. Most people don't understand how strong the regulations and regulators are in each state, [making it] fifty different businesses. And in markets with more affordable products, more people participate than in those markets where products aren't as affordable.

SARA HOROWITZ: How many of you want to be dealing with your insurance in your retirement? Some of us are great day traders who

love figuring out what to do with mutual stocks, but the vast majority of Americans just want a trusted advisor to help them figure it out. That factor is not considered when we look at why people don't buy insurance. Some say that they think of themselves as "young immortals," but I don't buy that. Some say that it's people just don't know; I don't buy that, either. I think individuals lack the tools necessary to help them make decisions about retirement, health insurance, and other essential protections formerly provided by the social safety net but that now must be procured by the individual. The sophistication of these tools should be commensurate with the amount of risk that people are now supposed to be taking. We have moved beyond the affordability issue—that is, whether people can or cannot afford insurance—to a question of value. That's answer number one.

What's troubling about mandatory is that you have to pony up the money for enforcement; and if you're not going to enforce it, don't call it mandatory. We should have a national system of vouchers that is market-tested and won't scare people. We would have a minimum amount of coverage for all Americans, and then groups like mine and local chambers of commerce and others would be allowed to come together to provide basic coverage, plus additional benefits. Bringing people together allows groups to reduce administrative costs. You can then also pool the costs of expertise and provide advisors and experts to help make decisions easier, without taking away individuals' decision-making rights. In this way you make their decision-making process easier while adding more value for people in the group.

SHERRY GLIED: How many people have failed to do something on their "to do" list and did something else instead in the last twenty-four hours? In my view, this is the reason people who can afford it do not buy health insurance. It is fundamentally a "to do" list problem rather than a problem of not wanting coverage or being a young immortal; we see that when the same people who do not buy health insurance in the individual market take jobs, they sign up for the coverage that their employer offers them, even when the premium that their employer charges is quite high.

The reason for that is, when you begin a new job, someone walks into your office and says, "Here is the form for the health-insurance plan; please fill it out." And everyone fills it out, and it's

deducted from payroll. We see this in countless situations—Medicare, for example. A big reason people don't buy health insurance is that they just haven't gotten around to it. They are figuring that in, say, three months, they are going to have another job, so why bother to go into the non-group market and buy it now?

This inertia, and the fact that health insurance is just one of the many items on the "to do" list for most people, is a big issue in terms of the non-group market. I've spent the last eight months writing papers on individual mandates. I was initially skeptical, but I've come around full-circle and am now a fan. This has been a very slow evolution. I'm not a fan of Massachusetts, because I agree with Sara—it is not putting the money [into enforcement] that it needs to put there.

But I've always been a fan of universal health insurance, for a variety of ethical and moral reasons. If you are also convinced that you want to have a private health-insurance system, you have to be in favor of mandates because without them, you can never get from here to universal coverage. The countries that try to manage private health insurance, such as the Netherlands and Switzerland, do it with mandates. Whenever we want everyone covered, we do it with mandates; they won't work perfectly, but that's not the issue.

After I wrote a piece about mandates in the *New England Journal of Medicine*, I received a letter from a man at the Massachusetts Connector that was exactly on point. He said that a young man had come to him saying that he didn't really need to buy health insurance, but his mother said to him, "It's the law, sonny. You got to go buy health insurance in Massachusetts." That's why a mandate will make a difference; not because there's going to be a penalty but because all the mothers in Massachusetts will tell their children that they must buy coverage.

The seat-belt mandate works that way: kids get into the backseat of the car, and their moms tell them to fasten their seat belts. If they do not fasten them and a policeman stops them, they will receive a ticket for breaking the law.

TARREN BRAGDON: Now we will take questions from the audience.

AUDIENCE: I'm a practicing physician in Louisiana. I'd like to ask the panel to comment on the desirability, or lack thereof, of having

individuals buy their own insurance. If I were to go to eHealthInsurance, I would buy my own policy, much the way one buys a life-insurance policy. If you move from one state to the next, you can bring your life-insurance policy with you. Obviously, there would have to be, as Congressman [John] Shadegg [R-Ariz.] has said many times, changes in the law necessary to make that possible for health insurance policies.

Sara touched on my second question, which has to do with defined-contribution plans: whoever puts up the subsidy puts up the same amount of subsidy, no matter what choice you make. Please comment on the desirability, or lack thereof, of defined-contribution plans.

GARY LAUER: One of the many tenets of health savings accounts program is portability. Once you have a health savings account, you can own it for life. It is an intriguing idea, discussed by Congressman Shadegg, to break down the state market, so that we don't have fifty state markets—one could buy health insurance from any state. So I could live in New York and buy insurance in Ohio, where it's much less expensive. Where it gets complicated, however, is that each health-insurance carrier contracts with physicians, hospitals, providers, and so on. Insurance will work only in that network. Health insurance [for a New Yorker] is contracted with providers in New York, not in California. California health insurance is good in California but not in New York or Ohio. It starts to fall apart when you look at it from that standpoint, unfortunately.

In terms of incentives, many people don't know that individual insurance is not tax-deductible. Businesses can deduct 100 percent of the cost of health insurance from their taxes; individuals cannot deduct one cent. An interesting thing about all three presidential candidates—currently, Barack Obama, Hillary Clinton, and John McCain—is that their platforms on health all talk about incentives and reforms in the tax code. That may address a bit of this inequity in the system, which could be an incentive [to purchase health insurance] as well as a bit of a stipend making health insurance more affordable.

SHERRY GLIED: I'm a big believer in markets. In level playing fields, people tend to prefer large-group coverage. We see this in other countries as well as in the United States. Even the self-employed—who

can deduct the cost of health insurance—if given the opportunity, will get into the large-group market.

The rhetoric is bigger than the effect. I want to second the point that Gary made: health insurance is not like life insurance. It is not a cash transaction. It is not a fungible benefit. A health-insurance plan in New York is not the same thing as a health-insurance plan in Hawaii. If I buy health insurance, and next year I decide I need more, I have to buy an entirely new contract. With life insurance, if I don't feel I have enough, I can supplement my life-insurance contract. The analogies are not very clean.

SARA HOROWITZ: The point about the defined-contribution plan is interesting. We should be looking at what is happening with individuals, as we do with pensions, where we say that instead of having x dollars when you retire, we say you will receive x dollars each year as a contribution. We're asking individuals to bear a lot of risk. Are we creating systems that enable people to bear those risks successfully? There is nothing wrong with the strategy of a defined-contribution plan, if people have experts on pensions to help them figure out how they are going to invest and allocate the assets over time. With health, we don't have those tools in place. The institutions that people are connecting with—health insurance now—are not aligned with their best interests from the standpoint of health. We should be realigning those institutions.

DAVID HYMAN: To recapitulate: by owning your own insurance, you basically gain portability and the potential to avoid state regulatory frameworks that you don't like, if there are cross-border sales. The trade-off is that you forgo the advantages of group coverage, which I talked about previously. Sherry mentioned administrative expertise; you have a benefits person worrying about this all the time instead of having to worry about it yourself.

SARA HOROWITZ: It's not portable because if you discover a preexisting condition along the way, you get excluded by a new state, even if it has community rating. Portability means a person can go from job to job in a seamless system that is separated from your health status. In the individual market insurance is not portable. That is a fallacy.

DAVID HYMAN: No, that's a separate issue—and maybe it depends on what you mean by portability and where you plan on using it.

SARA HOROWITZ: I go from point A to point B, carry my insurance with me, and I want to know that when I leave A and get to B, I brought it there successfully. I don't want there to be a waiting period, or in three years, when we know our genetic code, [to lose] portability because of who I am.

DAVID HYMAN: I took the question about owning your own insurance to mean that you maintain the same individual coverage, which means that it's portable across your [various] places of employment. On the subsidy issue—the tax subsidy, or the amount your employer is contributing—matter a lot, just as they matter in other areas. Expecting people to buy health insurance today because they will be able to receive a tax subsidy in a year and a half is probably expecting too much of most people's forecasting ability, even very smart and sophisticated people with very good advisors.

AUDIENCE: Gary and Sara, by aggregating individuals, you make them more powerful, correct? But the two of you do it in very different ways. Sara says that she fights with the insurance companies and is an aggregate on their behalf. Gary is a purely economic aggregator. He creates a market where people can shop, and it is up to them to decide if they need to buy. Would you please debate the pros and cons of these two methods of aggregation?

SARA HOROWITZ: Before we arrived here, we said that we could be working together in different markets and that we should meet afterward to figure that out. I think it's a good debate. Your competitors are often your best partners.

GARY LAUER: I don't know how much of a debate there is. What Sara is doing is fascinating, but there are some problems with it: ultimately, the payer is the health-insurance company. It's not Sara, and it's not me. Whether there are 17,000 people or 117,000 people, the health-insurance company is the arbiter. It gets to decide what the price is going to be. It also gets to decide what it is going to

pay for and what it is not going to pay for. It gets to decide how to mitigate the risk.

A couple of years ago, we took a look at this vertically. One of the verticals was car dealerships. Manufacturers have fabulous health insurance—there is a long history there. The dealers and dealer franchises don't. One manufacturer asked us to consider covering all its car dealerships. We thought that it was a good business opportunity and a way to help a lot of people.

But we found that they really weren't insurable because the people in the front sales office have high rates of alcoholism and smoking. This is a fact. And the people in the back who repair the cars are very accident-prone, as you might imagine: not a very good risk group. I'm giving you a bit of the extreme, but my point is that when you get together a [particular] group of people, you have [a certain level of] risk, and that risk is going to be assessed and priced by the health-insurance carriers. If you bring a demographic or a group that represents a level of risk that is attractive, it is going to be priced attractively. If it is not attractive, it will not be priced attractively. That is the way that this business operates, whether you like it or not.

The other point I wanted to make is about the purchase of health insurance. This is not a pleasant process. If you've never purchased insurance for yourself, or your employee, or your family members, I challenge you when you go home tonight to pull out your health-insurance policy and start to read it. It is complex and daunting. It's much more fun to buy a car or a flat-screen TV. One thing that we have tried to do as a marketplace is to corral this complex volume of data and reduce it to something more understandable to people.

But analyzing health-insurance plans is not something that people care to do, so they procrastinate. If you are a member of Sara's group, it is easier simply to sign up than to go to the individual market and buy a policy. But the market today is changing in such a way that more people are going to have to buy their own health insurance. We have an obligation to make this a market in which people can gain access to programs that will work for them.

SARA HOROWITZ: The fundamental difference is solidarity. What I mean by that is we didn't create a group like Sam's Club to just

come and buy, though there are definitely elements of that. We found people who are a naturally occurring group and started realizing how they could come together. That is what we should be thinking about. How do we encourage naturally occurring groups—not government-subsidized groups—to come together? It is good not just for health insurance but for democracy. It goes back to an idea of Alexis de Tocqueville and what our democracy is supposed to be about.

AUDIENCE: I have a question for Gary on the debate over what's wrong with New York's market and what's right elsewhere. You are basing your average process on people who purchased through eHealth. You don't have a comparable sample in Ohio that includes the [unhealthy] people who couldn't purchase because Ohio doesn't have guaranteed-issue. These people had to join a high-risk pool [and pay a] 300 percent premium, unlike sicker people in New York, who can buy insurance under the guaranteed-issue system. Is that a reasonable criticism?

GARY LAUER: That is a very fair point. There's another side to it, however: don't assume that sick people who have guaranteed-issue can afford health insurance.

AUDIENCE: That's the perfect connector to the rest of my question, which is directed to all of you. You've all shown how there are winners and losers when we change any one of these regulatory characteristics. If we go to guaranteed-issue, the older people whom I represent are going to do better, and the young, healthier people are going to do worse. If the goal is universality and comprehensiveness of coverage, why are you all clinging doggedly to the virtues of the private market as a way to resolve this, rather than the social-insurance model that David mentioned but didn't really discuss in this context?

SARA HOROWITZ: We are at a fork in the road. The way the fork had been presented in the past was the free market versus government. The question had been whether individuals were going to get a Medicaid system or, instead, an individualized free-market system. The other fork would be a non-employer-based, nongovernmental grouping.

There is no way that we are going to have a government deliver this. [Or an] unfettered free market. So let's reframe the issue

and ask, do we want individuals to [handle] it, or do we recognize that people need trusted groups? To me, that is the fork.

GARY LAUER: I've spent a lot of time on this question over the years and have concluded that the old definition of universal, which is a government-sponsored management system, is not practical and is simply not affordable. I also think that we have a moral and an economic obligation to get everyone in this country good-quality health care. It needs to be a combination of the private sector—much of which works well—and public programs, presumably for people who [simply] cannot afford health insurance, or who cannot afford it because of their health condition. We're paying for them now, anyway.

SHERRY GLIED: I would agree. There is no single model of a universal public insurance system in the world today. All countries are struggling with the division of public and private. This is true everywhere: Canada, Germany, France, the Netherlands, and Switzerland. The questions are: What is the appropriate size of government? And what is the appropriate role for the private market?

For social-insurance fans, this is a moment for optimism. In the United States, we think of universal health insurance as being a black or white issue. We're either going to go to universal single-payer, or we're not. But consider how other countries moved into universal health insurance: mostly, they did it incrementally. It took Canada fifteen years from the time the first province brought in universal hospital insurance until the last province brought in universal medical care. There's no reason to believe that this has to happen suddenly.

DAVID HYMAN: First, the rate of increase in health-care spending is quite consistent across different types of insurance systems and across countries. All systems are struggling with matters of demographics and technology. Second, the only person who is advocating a universal social-insurance system is Dennis Kucinich, and we saw what happened to him. You're going to need a lot of years and reframing of the debate for that to be one of the two options you get to pick from.

PANEL II: INNOVATIVE SERVICES IN HEALTH CARE MARKETS

PAUL HOWARD: For individual patients trying to find the best, most cost-effective health care, there are relatively poor metrics concerning pricing and quality that are available. If you're looking for someone to tell you who would be a really good doctor in your area, there's relatively little help for you, aside from a few lists of the top-ten doctors in New York. But the average patient doesn't need to know who the top doctors in New York are; they just need to find a reliable, convenient option for routine care. There's a Zagat's for New York restaurants. Why isn't there a consumer friendly, Zagat's-like guide to doctors and health care?

At the system level, periodically Dartmouth College—John Weinberg and his colleagues—reports data on pricing disparities in hospitals across the country, particularly for [treatment of] chronically ill Medicare patients. In a study released in early April, Dartmouth researchers found that some of the nation's leading hospitals will spend about twice as much money, close to $100,000, on patients in their last six months of life, while other leading hospitals are spending half that sum. To paraphrase Peter Orszag, director of the Congressional Budget Office: How is it possible that the world's best health care can cost twice as much as the world's best health care? If the experts can't figure it out, what hope is there for the average patient?

Our second panel this morning is going to try to chart a way forward through all this confusion to offer examples of how entrepreneurs, physicians, and policymakers can make health-care options more convenient, transparent, and affordable for consumers.

We're starting off our second panel with Kevin Kelleher, a physician in private practice and cofounder of Executive Healthcare Services. Kevin is going to give us a physician's perspective on the crisis affecting primary care in this country and explain why the decline in primary care is hurting public health and driving up health-care costs. He'll conclude by suggesting some ways to reinvigorate primary care by creating a new medical home for patients—where the primary care physician works with the patient to develop long-term disease prevention strategies or help coordinate team care for complex chronic diseases like diabetes.

Webster Golinkin, CEO of RediClinic, will discuss another aspect of the market: the expanding role of convenient-care clinics, which complement the health-care system while giving people rapid access to preventive and basic health-care services. These clinics have proven to be remarkably popular and affordable, but they are being held back by misplaced regulation in some states.

Our third panelist is Jim Ward, president of Patient Advocates, who is going to talk about the hospital pricing and quality disparities that I mentioned a moment ago, and how we might arbitrage some of those differences to offer patients better care at lower costs.

Finally, Jim Frogue, project manager at the Center for Health Transformation, will discuss consumer-driven health-care reforms that are emerging at the state level. He'll talk about how the state of Georgia, in particular, is embracing market forces to improve access to affordable health-insurance options.

KEVIN KELLEHER: I'm a practicing family physician in Virginia, and I currently own a traditional primary-care family practice office as well as Executive Healthcare Services, which is a retainer-style, or prepay, office that was started four years ago.

Let me say first that any reform of the U.S. health-care system needs to be founded on primary care as the source and director of the health care delivered. I am going to give you my perspective on that and tell you about some of the things that we've done at Executive Healthcare Services.

There is ample evidence that health-care models centered on primary care are the most cost-effective. Outcomes improve, cancers are detected earlier, and mortality is reduced.

There is ample evidence that health-care models centered on primary care are the most cost-effective. Outcomes improve, cancers are detected earlier, and mortality is reduced. Money is saved in both outpatient and inpatient care. So a system founded on the concept of a patient-centered medical home is touted in academia, medical organizations, and even our own Centers for Medicaid and Medicare Services, but it is not often seen in the market.

Studies in the United States and abroad show that outcomes are improved when doctors have more time to spend with their patients and when doctors are allowed to address preventive issues that are pertinent to that patient during a visit. When care is made accessible and relationships are established, money is saved through control of chronic disease, reduction of inappropriate emergency-room visits, and decrease in redundancy of testing and procedures.

Paul mentioned Dartmouth data, which are a good source for tracking these specific numbers and for demonstrating how, if primary care is the center of care within a county, health-care costs are usually lower than they are in counties that aren't as heavily occupied by primary-care doctors.

What is the current American medical office like these days? The primary-care office tends to be a model based on high volume, minimal doctor-patient time, limited scope of visits, and a knee-jerk approach to medical care that is reactive, not proactive. Most of us have experienced this in one form or another. The office itself is focused on back-office functions much more than on patient care. You can look at Medical Group Management Association (MGMA) data on how many full-time employee equivalents support each doctor. Out of the 3.8 per doctor, usually two are geared toward back-office functions, not health-care delivery.

Medicare physician reimbursements have been either flat or declining in recent years, and their failure to keep up with the cost of living and inflation have demanded more patient visits during a day, just to keep a medical practice running. Insurance follows most of Medicare's rates and has implemented further tactics to reduce payments. Procedures are bundled: If I'm seeing someone for a physical who also has a cold—or worse, a new knee pain—I wont get paid for the evaluation and treatment of that problem; I can only do one or the other. This impairs a doctor's ability to offer comprehensive care, including taking care of an immediate problem.

By comparison, thirty minutes for a typical specialist procedure is usually reimbursed at a rate three to ten times higher than thirty minutes for the discussion of chronic health issues with a patient.

As large insurance companies swallow up smaller ones, we have arrived at a system in which 60 percent of privately insured individuals are covered by three companies. This oligopoly is further reducing support for primary-care physicians delivering good-quality care.

In the next ten years, approximately 35 percent of our population will be over the age of fifty. The need for good primary care and good preventive services increases, and screening issues will increase substantially, but who is going to be delivering these services?

Just as the demand for primary-care doctors is increasing, the supply is diminishing. Since 1997, the number of U.S. medical-school graduates entering family-practice medical residencies has dropped 50 percent. And 80 percent of internal-medicine graduates are going into subspecialties, not into primary care.

Practicing primary-care physicians basically have responded by reducing services on site. They are increasing problem-related referrals for issues that they could have addressed but that they don't have time to address, and turning to high-volume, single-problem visits. They are forgoing inpatient care of their own patients. And they are choosing early retirement: a recent study suggested that a third of doctors over the age of fifty will either change careers or reduce their services or their practice of medicine in the next ten years.

So the majority of office-staff energy and time is focused today on the insurance process and accounts receivable rather than on patient care and outcomes. This is not a model that any of us wants to be part of.

Small and large changes are needed. We talked about a lot of them on the first panel. We all know that fundamental changes are needed in payment systems, tax structures, and tort reform. Health information technology should be encouraged in all sizes of offices and needs to be founded on data portability and on improved communications between physicians and specialists as well as with patients. We need to utilize proven remainder and recall systems such as recare programs, reminder cards, autodial systems, and chronic-disease care algorithm forms that are effective in reducing costs for chronic care. And we need to employ chronic-care treatment models and decision-making tools based on best practice.

The health-care system needs to shift toward primary care as the foundation of health-care delivery by realigning public policy and initiating programs that encourage the brightest and best medical students to go into primary care. Today, these students are simply not choosing it.

Once in primary care, these doctors must be allowed to practice the trade that they learned, which is personalized, comprehensive,

coordinated care distributed to people in an ongoing manner. The current system does not support this.

Compensation must promote cognition and quality, not procedures and quantity. Compensation should not be based purely on actual visits but should be afforded to the coordination of care, office communications among other providers, and third-party medical serivce providers. Remote monitoring of clinical data is very important and should be compensated. Physicians who distinguish themselves by efficiently providing medical care and by achieving measurable and successive quality objectives should be rewarded because, as ample evidence shows, it saves money for the system.

In the short term, there are steps toward this paradigm. My Executive Healthcare Services is one small step, and you're going to hear about others. But some primary-care physicians' offices are forgoing out-of-network insurance contracts and contracting with the patient for payment of services [in the form of prepaid [policies] or retainers, but also [in the form of] simple out-of-network fee-for-service.

Businesses have implanted worksite wellness services and on-site clinics because they can realize cost savings by focusing on prevention. Both models begin to directly involve whoever is paying for services with the services they receive. This happens in most other markets. In health care, we've gotten away from that.

In these new relationships, day-to-day options and decisions aren't dictated by third parties. Instead, health-care relationships are founded on partnerships with the shared goal of improved health, and cost is measured and becomes improvable.

The patient starts to become a major participant in the financial and medical choices that affect care. Time is of the essence in medical care; but [doctors should spend] time dealing with cultural and social obstacles that [limit] [a patient's] health choices and discussing, coordinating, and offering follow-up care in an expedient manner. Additionally, my office—and this model generally—puts patient care first and minimizes the need for back-office functions and keeping the practice alive day to day.

Not all these models are successful when they start up, but that's good—it suggests that patients take very seriously the extra expenditures [they must make] for their health care, and that they are scrutinizing the quality of services they're receiving. The disconnect

over many years between patients and doctors has made paying for one's medical care a foreign concept. My experience at Executive Healthcare Services shows that people realize benefits far beyond what they expected from a model that delivers good care. We are extremely accessible to patients. Over a period of more than four years, our model has achieved a 97 percent patient retention rate with patients who can choose to leave at any time they want—they're month-to-month. I am happy that a patient said to me recently, "Good medicine takes time." Once a patient experiences this, he often realizes what he has been missing in the current system, and the bond that's established between patient and doctor guides him through all the other health-care choices.

WEBSTER GOLINKIN: I'm CEO of RediClinic, which is one of the leading operators of health-care clinics in the United States. I'm also president of the Convenient Care Association. I'd like to talk to you from the industry's perspective rather than my company's perspective. I'll briefly describe what convenient care is, why it's growing so rapidly, what can slow its growth, and where I think this is all going.

Convenient-care clinics are small health-care facilities located in high-traffic retail outlets with pharmacies. In RediClinic's case, we're in Wal-Mart's Supercenters and in H-E-B grocery stores, and we were in Duane Reade drugstores in Manhattan—but that's another story that I'll mention later. These clinics are usually staffed by nurse practitioners or physician assistants. Nurse practitioners, as you probably know, are registered nurses with master's degrees (or comparable training) who are licensed to treat, diagnose, and prescribe medication for a limited range of medical conditions. Convenient-care clinics offer a limited scope of practice, so they typically treat twenty-five or thirty common conditions—e.g., earaches, strep throat, pinkeye—the kinds of things that are not life-threatening but will certainly get you down if they are not attended to.

Convenient-care clinics also administer a fairly broad range of services, depending on the operator, including health screenings, medical tests, immunization (including flu shots), and basic physical examinations. Simple things can be done relatively quickly. They're open seven days a week, one doesn't need an appointment, and

because of the limited scope of practice, a visit typically takes about fifteen minutes. Again, because the scope of practice is limited and we have the luxury of specialization, it's quite an efficient process in terms of time and cost.

So they're affordable—usually less expensive than other health-care-delivery outlets. All prices are prominently posted at the clinic, so patients know exactly what they're going to pay before they receive their treatment. Increasingly, operators have contracted with managed organizations or other third-party payers, so mostly they will take your co-pay. They're serving the store's shoppers and employees as well as consumers in the trade areas of those stores.

All prices are prominently posted at the clinic, so patients know exactly what they're going to pay before they receive their treatment.

The industry has grown rapidly and quite remarkably over the past few years. When the Community Care Association was founded about a year and half ago, there were about 150 of these clinics in the United States; today, there are nearly a thousand. The industry has treated more than 2.5 million patients since its inception, with no safety issues that anyone is aware of. It is projected that there will be about 1,500 of these clinics by the end of this year; some say as many as 5,000 by 2010.

Why is this industry growing so rapidly? Frankly, the growth has surprised even me, given the various obstacles we've encountered in making consumers aware of the concept, persuading retailers to let us place clinics in their stores, and getting third-party-payer contracts.

The answer is simple: there is tremendous consumer demand for easier access to high-quality, affordable health care. Consumers are just not receiving it any other way. And there is a growing primary-care physician shortage. It's hard to imagine that this problem is going to get any easier for consumers. If you look at the research that's been done on preventive care, depending on the survey, between seven and sixteen percent of consumers have tried convenient care, and 30 to 41 percent say that they intend to try it. That translates into millions of consumers. The outlook is bright in that respect.

Other constituencies are embracing convenient care. Retailers now say that they want these clinics in their stores, and third-party

payers see this as an opportunity to cut some cost out of the system while keeping members and subscribers happy. Policymakers say the same thing, which is that we have to do something to stem rising health-care costs. This is certainly not a silver bullet but is possibly part of the solution.

Basically, four things could slow the growth of the industry. One is systemic clinical quality issues. There has been some conversation about whether the quality of care provided at convenient-care clinics is adequate. There may be incidents; remarkably, there have not been any so far, but there are incidents in other health-care-delivery systems every day. So I would be a fool to say that this won't happen. But will there be systemic clinical quality issues? I absolutely don't see it, because the nurse practitioners and physician assistants who are staffing these clinics are very well trained for the limited scope of services that they are allowed to provide. They use evidence-based protocols and electronic medical records, and their companies conduct compliance and outcome studies. They have physician oversight at every clinic and local referral networks. They're in compliance with applicable regulations. I think convenient-care clinics are going to turn out to be better in quality of care for the limited scope of services that we offer. It's purely a function of specialization.

The second thing that could slow the growth would be a shortage or increase in cost of nurse practitioners or physician assistants. Clearly, there's a nursing shortage in the United States. There are about 140,000 nurse practitioners, and maybe 40,000 physician assistants. The system is graduating five thousand to six thousand in each category annually. There has been an adequate supply of what have been referred to as mid-level practitioners to sustain the growth of the industry because nurse practitioners see convenient care as an appealing new career track, where the compensation is competitive, and they get more autonomy than they are accustomed to and, in some cases, more predictable hours. We have diverted some nurse practitioners from other career tracks that they could have taken. That has sustained the growth of the industry. There are obviously issues here, such as the need to do a better job of building educational capacity in this country to fulfill a growing demand for mid-level practitioners, and there are various initiatives afoot to do that.

The third thing that could slow clinic growth? Maybe the business model itself doesn't work. There have been a number of highly

publicized failures of convenient-care operators over the past year or so, mostly smaller companies. Clearly, some have underestimated the capital requirements of this business. It seems like an easy business to get into because it's not extremely expensive to open a business, but it takes several hundreds of thousands of dollars to sustain unit to cash flow breakeven. Because the business model hasn't really proved itself yet, the probable path is uncertain.

There will be some consolidation in the business. Success will come with increased consumer awareness and third-party-payer acceptance, which is happening. There will be some creative and appropriate scope expansion—again, within the limit of the fifteen-minute visit. I can assure those who think that convenient care is a Trojan horse for putting a full-service medical practice in a grocery store that that would entirely destroy the business model. If we didn't have a limited scope of practice and if we weren't able to get a patient through in fifteen minutes reliably and predictably, the value proposition would fundamentally be destroyed. So there is an upper limit on scope expansion.

Convenient-care operators are becoming more efficient, and better at understanding what kind of promotional vehicles work and don't work and getting more support, not only from retailers but from other elements of the health-care-delivery system. RediClinic has partnered with leading health-care systems in every market that it serves. A couple of years ago, it was very hard to get other health-care systems to partner with us; today, we have a backlog of health-care systems in every market wanting to partner with us.

The fourth thing that could slow growth, and perhaps the [factor] most applicable to New York State, is increased regulatory impediments. There are already significant regulatory impediments to the growth of convenient care, but they've been manageable in most cases. These come in various shapes and sizes: clinic-licensing requirements; restrictions on nurse practitioners' scope of practice or prescriptive authority; physician oversight requirements; and, of course, the deadly prohibition against the corporate practice of medicine, which is particularly relevant in New York State.

New bills have been introduced in various states over the past couple of years that would put up even more roadblocks to the expansion of convenient care. I'm pleased to say that they've all

failed—because the sponsors of these bills are swimming upstream against consumer need and very high levels of patient satisfaction—in excess of 90 percent industry-wide. They're also swimming upstream against an increasing number of studies that show that the quality of care provided at convenient-care clinics ranges from very good to excellent. And they are swimming upstream against growing third-party-payer acceptance. Recently, the Convenient Care Association has been doing a better job of educating various constituencies.

These efforts to constrain the growth of convenient care will fail, but some states will be left behind [anyway]. New York State is lagging at this point. It has a strict interpretation of case law, as it applies to the prohibition against the corporate practice of medicine, which has made it one of the two least attractive states for convenient-care operators to function in, the other one being California.

I'll give you my own experience in New York State. Redi-Clinic made a deal with Duane Reade in 2005 and opened a couple of convenient-care clinics in its stores in Manhattan. We had four others under construction, but our legal bills were higher than the losses we were sustaining or were planning to sustain over the first full year of operation. I finally decided that, much as we wanted to be in the New York market, and saw residents there with no easy access to affordable health care, it just didn't make sense, when there were forty-eight other states [excluding California] where it was a lot easier and less expensive to operate. So we decided to pull out.

We have been replaced at Duane Reade by another company that private-labeled its clinics for Duane Reade. It is a physician model, so it is more compatible with the prohibition against the corporate practice of medicine in New York. I visited its website a couple of weeks ago and looked at its pricing. It basically charges 40 percent more than what we're charging for treating such conditions as strep throat and ear infections. Its expanded scope of practice makes it hard to believe that it can get people in and out reliably in fifteen minutes. I'm not saying that it doesn't do a good job or that it doesn't provide a valuable service, but it looks more like just another urgent-care clinic, not like what convenient care is able to provide.

MinuteClinic is the only major operator that is still here in New York State. It comprises seven units and has no plans for expansion. Other convenient-care operators have stayed out. This is a

passage from the report of the New York City comptroller last year: "The city and state should encourage the growth of drug and retail health clinics as a way of increasing cost-effective access to routine care and taking pressure off overburdened emergency rooms." But no progress has been made. I wish it were otherwise because Redi-Clinic, for one, would like to be in New York State. But right now, it's almost impossible for us to do business here.

Where will all this come out? I think the convenient-care industry is going to continue to grow, albeit at a somewhat slower rate than what some have predicted. There will be robust growth but not 5,000 clinics in the next two years—I don't think there is enough capital out there to do that. I agree with Kevin that not enough attention is paid to primary care, but it's going to be hard to turn it around. In five to fifteen years, convenient care is going to be one of the most important portals into our health-care-delivery systems.

JIM WARD: I want to thank the Institute for this opportunity to come and share with you some of the things that we're doing to manage health plans. When, I saw the title of this session, "Innovative Services in Health Care," I thought of things like the DaVinci Surgical Robot. So I went back to our play book, which is entitled *Who Killed Health Care?*, by Dr. Herzlinger, and somewhere around page 70 she describes "innovation" as that which "lowers health-care costs while raising quality." I felt a little bit better after reading that because we have been able to achieve that standard in our work with employer health plans.

My company manages self-insurance health plans primarily for employers in Maine and New Hampshire. We have the administrative capability to handle all the functions of the health plan. We enroll people, terminate people, pay health claims, send out COBRA notices, HIPPA notices, and pursue third-party liability. And we also have a nursing division, the heart of our company, which works with patients as they go through the healthcare system. I think what we do with our nursing staff and how we do it is what is different about us.

The fundamental premise of our company is that we have to have complete agreement before we can do business with a company. [One of our principles] is that the least expensive health care that one can buy is quality health care. That isn't just a slogan. Nine times out of ten, when we work with patients we will save them money and

enhance the quality of care. One time out of ten we are going to increase the cost of care—and in some cases dramatically increase the cost—in order to ensure that the patient receives the proper care.

The marching order for our nurses is to advocate on behalf of the patient throughout the system, as though the patient were their mother, father, spouse, or child. When you run into obstacles, you come back to us, and our job is to remove those obstacles.

Long term, fifty to seventy percent of health-care cost can be eliminated through wellness programs, early detection, and prevention. Our nurses go to the employer's location and offer wellness incentive programs. In the typical program, at the end of the year employees will get a check issued from the health plan if they achieve certain wellness standards, such as for weight, blood pressure, et cetera. The wellness process also introduces employees to our nurses, so that if and when the time comes that they need to enter the health-care system, a relationship has been established, and a basis for trust has been established.

Long term, fifty to seventy percent of health-care cost can be eliminated through wellness programs, early detection, and prevention.

The bad news is that Maine—and to a certain extent, New Hampshire as well—is a very restrictive market characterized by local health-care fiefdoms and monopolies. Meaningful competition is something you can find only in a dictionary, and that dictionary does not happen to be located in the local hospital.

The good news is that our clients are very fortunate to live anywhere from one-hundred to three-hundred miles north of world-class centers of medical excellence in Boston: Mass General, Brigham and Women's, The Lahey Clinic, Tufts Medical Center, and Beth Israel Deaconess, to name a few. What we have found is that Boston is a very competitive health-care market. It appears there is an excess of supply down there, those hospitals compete with each other, and they understand competition. So we have worked that reality into the benefit structure of our clients' health plans.

The typical plan offers a deductible of two-hundred-and-fifty to five-hundred dollars, with a co-payment of twenty-five dollars per

office visit, and reimbursements of eighty percent of major medical [expenses], to the point where the employee's liability maxes out. What we have experienced there is a range of savings of anywhere from twenty to fifty percent.

For example, a total hip replacement in Boston can cost $6,800. That's about a $40,000 ticket in Maine. And we're getting great results.

We have found that people are treated very well going through the system, and I'm not talking just clinically. They're treated with great respect. At The Lahey Clinic, for example, if you get there early, they take you early.

The clinicals at these institutions are great, we're saving a lot of money for our clients, and the outcomes are terrific. Most of the specialists our patients see are hospital employees, and they tend to treat in teams. So, for example, if we have a patient with an eleven o'clock appointment for a breast cancer consultation with a surgeon, it is not unusual for that surgeon to ask the patient to stay until three p.m. for a meeting with the treatment team. The patient will meet with a radiation oncologist and a medical oncologist along with the surgeon. This sends a very powerful message to patients about the respect in which they are held.

The local [situation] is quite often a contrast. You see the surgeon and then get a referral to see the medical oncologist in two or three weeks, and then if you're lucky you'll get to meet a radiologist, but not necessarily the one who's going to provide the actual treatment. That can often take four or five weeks. Meanwhile, the clock is ticking, and there's a perception by the patient that their cancer is continuing to grow. So it's been wonderful for our clients to get referrals into a [different] environment from that.

Gradually, we removed any obstacles to people receiving treatment in those referral areas. Our referrals are not only to the Boston area. We have referred people to Columbia Presbyterian, to Johns Hopkins, in Baltimore, to the Mayo Clinic, in Rochester, Minnesota, and as far west as the UCLA Medical Center based on certain medical specialties [they offer]. We're trying to find the places where they do certain procedures better than average. The results, according to patient feedback, have been great.

Procedurally, if patients want to have treatment in the Boston area, they contact our nurses. We triage—we would not refer, for ex-

ample, simply for a routine x-ray. However, if it's a potentially serious case, we will make all the arrangements and referrals for them.

Since we've been doing this so long, we have developed relationships that enable our patients to be seen within a very short window of time. When a patient is referred to Boston, we will pay the bill at 100 percent—pay their transportation costs and the lodging of a family member or close friend while they are there—and we still save money. It's a way of passing savings on to the patient. If you want treatment locally, we'll support you in that process just as enthusiastically. The net result is that we're saving roughly between ten and fifteen percent on total employer health costs each year.

I looked at a case this past Friday—a group of five hundred employees in Portland in a very competitive business. This employer has had a rough two years, and we added up what we've saved it in the past year just by sending patients down to Boston. The total was $450,000. It would have to sell a significant amount of product to put $450,000 on the bottom line.

The late speaker of the House, Tip O'Neill, once said, "All politics is local." I think to a certain extent all health care is local as well, and we're seeing huge economic and quality disparities in different local markets. We're always trying to find good-quality alternatives.

JIM FROGUE: I want to talk about the bill that just passed in Georgia, which could potentially be one of the most impactful health-care reform bills enacted in any state. We gathered together all the leading health stakeholders—patients, physicians, health insurers, and brokers—in one room to address the problem of the uninsured. These groups—who are at each other's throats for just about everything else—could agree that there was a problem, and it was something they wanted to help fix. So we asked, "What are some things on which we can agree? We can't solve all the problems here in one sitting, or in one session, or even in just one session of the legislature. But what can we do to make at least a huge dent in the uninsured population in Georgia?"

We decided that one of the biggest—if not the biggest—segment of the uninsured is people who make over $50,000 a year. In Georgia, that number is almost a third of the 1.7 million without coverage. That's a little over 500,000 people, which is quite a high number. These people—at least by our definition—choose not to buy

health insurance. They could afford at least some kind of coverage, but they choose not to purchase anything for a variety of reasons, primarily because they don't see value. We decided to aim our reforms at this segment of the market: people who would likely buy policies if they had better options.

This bill will be signed into law by Governor Perdue next week. We think it will be pretty radical and accomplish a handful of things. First of all, it will eliminate state premium taxes on high deductible health plans. The premiums for high deductible health plans will be 100 percent deductible against Georgia income taxes. Small employers, defined as anyone up to fifty employees, receive a tax credit of $250 per employee for high deductible health plans they purchase. Considering that 70 percent of firms with less than 10 employees in Georgia don't offer coverage, we think this is the right kind of incentive. Also the bill will allow Georgia's Health Insurance Commissioner to grant fast-track approval to out-of-state HSA plans so that they can be sold in Georgia. New York, more than any other state in the country should do the same. States like New York, New Jersey, or Maine, that have major problems with their markets, instead of going through the rigmarole of passing a bill like this, all they'd have to do is allow their citizens to buy products based in Georgia. That's one simple tweak: eliminate the Berlin Wall and let them go buy in a different state. Even if it's just one state like Georgia, let New Yorkers buy there. We'd be happy for the business. If you can't create the products and business in your state, send people to Georgia.

But what we're most excited about is that the bill frees up health insurers to offer financial rewards and incentives for specific patient behaviors. The overwhelming majority of people's health status is behavior-based. The doctor or hospital you go to, the health plan you're in, the genetics you have, all of that combined, makes up far less than half of your health status. People always forget that. Political discussions almost always miss that biggest point. Democrats want to finance it this way, Republicans want to finance it this way—when behavior, more than anything else, determines health status.

Can financial mechanisms affect health status? We think the evidence shows that they can stimulate the right behavior changes. We've already seen it with quite a few plans. High deductible health plans reward people specifically, either through direct payments or

through reduced co-insurance or deductibles, for healthier behaviors. Broad studies of HSAs or HRAs show middling results in patient satisfaction and health outcomes. But we're not interested in copying the middle or the bottom half; we're interested in copying the best. And the best are very good, much better than what currently exists elsewhere in the private health insurance market.

The consumer-directed plans that work extremely well do four things, which we call the "four C's." They're cash, competition, communication and culture. The first is cash. People respond to cash or cash-equivalent rewards. How many of you flew here and chose an airline based on the miles you have on that airline? Those little things have a huge impact. Competition, at least in larger group plans, stimulates behavior change as well when it is you vs. your officemates, or your sections vs. the guys in accounting. Communication is absolutely key. One of the biggest problems in consumer-directed care plans is the CEO will read an article in the *Wall Street Journal*, probably written by Regina, and he'll go to his H.R. director and say this is great; let's go do this. And the H.R. director, who's 58 and about to retire, thinks it sounds like so much work. So she half-heartedly creates an HSA option, but nobody enrolls in it. That happens all the time. Successful plans have aggressive communication strategies from the CEO on down that educate people on how they can be rewarded by taking full advantage of them. And then there's the fourth C: culture. Culture must change in order to improve health status.

Can financial mechanisms affect health status? We think the evidence shows that they can stimulate the right behavior changes.

I'll walk through one example. The Alegent Health System, based out in Omaha, put together a very interesting consumer-directed plan that started in January in 2006, and they now have 2 full years of data. The Alegent folks gave their employees a choice of plans. They didn't kick everyone into a consumer-directed plan against their will. They kept the old PPO arrangement for people who were comfortable with that. However, over 75 percent chose one of the consumer plans, and that figure is 92 percent today. The consumer plans literally pay people $100 to take a health risk assessment or pay

diabetics $250 to meet certain health metrics. Smart people with their money at stake realized that these little payments have huge impacts on the backend by avoiding emergency room costs and other costs that are much more expensive. So Alegent goes out of its way to make sure people are completely covered. They use over three times the national average in preventive care. Their employees rolled over $2 million in balances the first year and double that in 2007. By the way, their overall cost trend for 2006 was 1 percent while achieving significantly better health outcomes. That's well below the national average. In fact, we did an event on Capitol Hill on April 8th, and we would encourage you to view the webcast archived on our website at healthtransformation.net.

Again, we're not interested in copying the average or the bottom; we're interested in copying the top. Some plans are extremely effective, so what is it about those that we can emulate?

Our work in Georgia is not done. The bill has passed and we're waiting the governor's signature. We now have a working group of our clients focusing on what kind of products can be created under this new law. Our brainstorming sessions will meet on a regular basis and walk through what could work. I think the products you're going to see coming out of Georgia in the individual and small group market are going to be the most innovative in the country. So keep an eye on Georgia in the next few years.

PAUL HOWARD: What we've seen on this panel is a continuum of innovative solutions to health-care problems. We have a wide variety of health-care services that consumers can utilize, based on their health status or perceived need for health care, from prepaid primary care and RediClinics for chronic and routine ailments, to consumer-friendly options for even much more serious illnesses. I'd like to ask the panel what more we can do to raise public awareness that these new products and services are out there, and that they work.

KEVIN KELLEHER: People need someone—a trusted intermediary—to help them navigate their health-care options. On the first panel, Sara Horowitz brought up decision-making: Should someone decide to spend money now on insurance for himself? Is it a cost or a benefit to hold that $3,000 himself in his pocket every year instead of paying a higher

premium for more comprehensive insurance, or not to purchase any insurance at all, given the chance he may not need medical services? It's hard for someone to decide that on his own, but the programs we discussed today can at least enable someone to look at what options are out there. Even more creative marketing and education plans are probably going to come up in Georgia over the next couple of years.

What are the available options for health care, and how would it be best to receive them and utilize them? Entrepreneurs have to make it easy for consumers to answer those questions and understand how they're going to pay for care. I don't have all the answers, but I'm sure unique, creative business opportunities are coming up.

WEB GOLINKIN: Let me suggest how convenient-care clinics deal with this. We have supervising physicians at each of our clinics who are available to nurse practitioners 24/7, who enter into a collaborative practice agreement with them, and who regularly review patient charts. There already is that kind of connector into the local medical community. When we see someone who needs ongoing care and has a condition outside of our limited scope of practice or that we are not set up to provide, we first refer him back to his primary-care physician; if he doesn't have one, we help him find one.

Some misconceptions exist in the medical community about what convenient care is or isn't doing regarding the increased fragmentation of care. We're doing our part to minimize it as much as possible, but we need collaboration at the other end. We need primary-care providers and other players in the health-care delivery system who want to collaborate with convenient-care clinics to create a seamless web of care.

All care providers who are members of the Convenient Care Association—and that represents 95 percent of all the clinics in the United States—have electronic medical-record systems, which serve many purposes. One problem that we have in trying to connect with primary-care providers is that they might not have those systems or don't have the resources or desire to connect. Ultimately, we must have some kind of standardized electronic medical-record system in this country so that there is a common denominator. Without that, providers will become increasingly fragmented.

JIM WARD: I'll comment on the employer-based system, because that's what our experience is. We're finding that with employers aggressively managing their plans, only 50 percent of females over the age of forty are getting timely mammograms, and even a lower percentage of males over the age of fifty are getting prostate-specific antigen (PSA) tests. The plans have beefed up their preventive-care plans tremendously. It's not uncommon to for them [to offer] a thousand dollars worth of preventive care. The message is: we'll pay you more to prevent it than we're ultimately going to pay you to cure it. It's manageable.

Now, upon enrollment, patients will qualify for a discount up front if they agree to get timely preventive-care tests appropriate for their age and sex. They get the discount on the employer contribution up front. That's the type of thing that, at this stage, employers have to be aggressive about, but it's also the best business decision the employers can make.

JIM FROGUE: Our work has concentrated on the uninsured and how to get more people covered; but if we don't have new, creative, and more efficient delivery systems, it doesn't matter how many people are covered. A recent article in the *New York Times* stated that Massachusetts has about 300,000 or so newly insured. But there aren't more primary-care physicians there; it interviewed one physician who had a year's backlog in new patients.

Having insurance is very good and helpful, but you need someone who's going to treat you first. Some of the new opportunities discussed by this panel are going to help a lot in expanding affordable, timely access to health care.

LUNCHEON ADDRESS

HOWARD HUSOCK: I am vice president for policy research at the Manhattan Institute. It's not often that someone's thinking and writing have changed a field. That, however, is the case with Regina Herzlinger. It's no coincidence that so many members of both panels today mentioned her name and cited her work. It was her insight that the disconnection created by our current health-care financing system between consumer and doctor drives cost up and quality down. Her shorthand for the set of solutions she sketched—consumer-driven health care—has entered the language of both policy formulation and popular discussion.

The paradigm-breaking nature of her work is what caught our attention at the Manhattan Institute when we asked her to join the ranks of our senior fellows. So, too, did the fact that she spoke, as Adolph Ochs once put it, "without fear or favor." Professor Herzlinger's vision of a better health-care system for America in no way advances any one interest over another but rather seeks to secure the general interest. I suspect that you'll see that she spares no one.

Regina E. Herzlinger is the Nancy R. McPherson Professor of Business Administration at the Harvard Business School. She received her bachelor's degree from MIT and her doctorate from the Harvard Business School, where she went on to become the first woman to be tenured and chaired at that institution. Long before her groundbreaking work on health care, she was well known and honored for her expertise in nonprofit accounting and control.

Her books on health care include *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers* and, more recently, *Who Killed Health Care?: America's $2 Trillion Medical Problem—and the Consumer-Driven Cure*. Her many honors reflect the groundbreaking nature of her health-care research and writing. *Managed Healthcare* named her one of the nation's top ten health-care policy thinkers. Readers of *Modern Healthcare* selected her as one of the hundred most powerful people in health care, and *Money* magazine dubbed her the "godmother of consumer-driven health care." Please welcome my colleague and friend Regina Herzlinger.

REGINA HERZLINGER: What's the problem with health care? People seem to talk at cross-purposes because they are addressing different problems, so their solutions are very different. The major problem with health care is that it's a very bad value for the money. The quality is very uneven, though we have great doctors and hospitals.

We are on the brink of an enormous scientific revolution in medicine, which will enable medicine to cure diseases through understanding the mutations in our genes and by creating diagnostics and therapeutics that deal with those genetic imperfections.

Yesterday's *New York Times* featured a mind-blowing article about gene therapy, which has been the holy grail of genomics. Gene therapy was actually enabled in some people who were congenitally blind. This article marks the beginning of astonishing changes in the way that medicine will be able to cure and reverse diseases. The U.S. leads the world by far in investment in that kind of research. But we also have uneven quality. Nearly 100,000 people are killed by hospital errors every year.

We also have issues with cost. That is demonstrated by General Motors claiming that it costs them $1,600 per car in health care, while Toyota [spends] $100 per car. GM's is likely a phony number that it has [inflated] to make its case—General Motors would love to dump its health-care program and go to a single-payer health-care system. However, the numbers are in the right ballpark. Let's say that health care costs General Motors about $1,100 per car produced and that for Toyota, it's about $300. That's still an $800 differential in health-care costs between the two manufacturers. Can General Motors engineer out $800 worth of costs in areas other than health care in order to be price-competitive with Toyota? I don't think so.

In my long career, I've been on the boards of directors of many large companies. As our other speakers have told you, in the United States, uniquely, the employer community plays a major role in buying health care. Employers are burdened not only by our excessive health-care costs—we spend 17 percent versus the 9–12 percent of GDP that other economies spend—but also by the fact that they pay much more as a percentage of their total spending than do employers in any other country.

The reason is the little tax wrinkle that allows my employer, Harvard University, to take $15,000 of my salary and use it to buy

health insurance for me on a tax-[deductible] basis. I do not have to pay taxes on that money. Harvard University [buys my health insurance], but I wouldn't have it buy my car, my clothing, or my housing. Smart as it is, it has no idea what I consider value for the money.

So American businesses buy health insurance. Overwhelmingly, it's large businesses with big staffs to buy health insurance, though it's a big distraction for them.

I have never met a CEO who said to me, "You know what I love about my job? I love buying health insurance." I've met CEOs who have said, "Get me out of here. If only the tax code could change, I'd cash them out and be rid of this albatross."

Buying health insurance is an albatross because they don't know what you and I consider to be value for the money. Here, in the richest country in the world, more than 40 million people are uninsured. People who earn over $75,000 a year are experiencing some of the fastest-rising rates of un-insurance. That income puts them in the top 20 percent of American wage earners. [Such] people do not buy health insurance, even though in theory they can afford it.

Why don't they buy it? It may be that it's inconvenient to do so, as Professor Glied hypothesized, but it may also cost too darn much, since $75,000 in Massachusetts, after taxes, is $37,500. Health insurance in Massachusetts [for a family] costs $15,000 if you don't receive it through your employer and have to pay for it out of pocket. No family is going to buy health insurance [that costs so much]. They have their mortgage, their children's education, and their food and housing [to pay for].

We have another big economic problem: job lock. Most of the growth in the American economy comes from small businesses. Many people working in big companies would love to work in small entrepreneurial companies, but they don't leave; they're locked into their jobs because the small-group and individual [health-insurance] market is such a poor one. They're afraid of what will happen to them if they have to go out and buy health insurance.

What I mean by "underinsurance" can be demonstrated by discussing the first great drug for genomic mutations (SNPs), which is made by Genzyme, a company located right next to the Harvard Business School. Genzyme earns $1.2 billion from this one drug. If you have a [certain] genetic mutation and you take this drug,

you live. If you don't take the drug, you die. Some 6,000 people take this drug. The drug costs $200,000 per person, per year. If a person's health insurance tops out at $1 million, the person becomes uninsured and uninsurable after five years on this drug.

Thus many people are underinsured, even though they think they have insurance. New York State has this problem. It spends more as a percentage of its gross state product than the U.S. as a whole, and its rate of growth of health-care costs exceeds that of the U.S. as a whole.

So why is there erratic quality and high cost in health care, whereas in industries such as retailing, automobiles, and computers, cost as a fraction of company income has gone down and quality has substantially improved? I pointed out the automobile and computer industries because most people don't have a clue as to how they work. I graduated from MIT, and when I had to program a PDP-11, which cost $150,000, I had to talk to it in machine language. Today, my cell phone, for which I paid $99, has more computing capacity than that, and I can talk to it in English. So how does it happen that complicated products like cars, which are essentially a series of microcomputers, have gotten better and cheaper while health care, which is also very complicated, is of erratic quality and has high costs?

The difference is that in cars, retailing, and computers, consumers do the buying and use their own money. As a result, we have a lot of choice in automobiles—there are 250 models of automobiles. You cannot have a competitive market unless products are differentiated so that people can choose items offering different value for the money.

Let's look at choice in the U.S. economy. The number of books published [per annum] has grown by 50 percent, to 185,000. More books create more competition, and competition increases productivity.

Even the number of brands of chocolate, something we hardly need, has gone up by at least 20 percent. What is the underlying dynamic here? If the Mars company introduces increased choice and the marginal revenue turns out to be less than the marginal cost, it's not going to keep doing it. So the fact that there is more choice means that consumers are responding and that it is worthwhile to be innovative in these very competitive markets.

Health care is very different. Employers and governments do the buying. Harvard University brilliantly manages a $30 billion endowment, but when it comes to buying my health insurance, it is not even close to giving me what I want. And when I go into Medicare, it's going to be the same thing: I'm just not going to get value for my money, and it uses other people's money. People think that health insurance is free; but your salary is being lowered by the amount of your health insurance, which is why income has remained flat.

When companies use your money to buy health insurance for you, no matter how well intentioned they are, you will be offered much less choice than you would if you were spending your own money. As a result, we have very little choice. There has been consolidation among health insurers all over the U.S. There are now three or four very large health insurers. There has also been consolidation among hospitals. In some parts of the country, 80 percent of all admissions occur in one hospital system. They're monopolies, and when there are monopolies or oligopolies, there is virtually no price competition. In fact, costs increase, and sometimes there are quality problems as well. In addition, there is very little product differentiation in the hospital, doctor, or insurance market.

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Health insurance is a trillion-dollar market, yet we have only two types of insurance policies. One is called a PPO (preferred provider organization), and you can see how incredibly consumer-unfriendly this market is, because no one even knows what it is. The second is called an HSA (health savings account) or an HRA (health reimbursement arrangement) and is sometimes given the misnomer "consumer-driven health care."

When you ate yogurt or whatever you had for breakfast this morning, if you looked on the side of the package, you saw a lot of information, right? You have the price and nutrition information right there. Suppose you had breast cancer or prostate cancer and

needed to find a hospital or a doctor. How much information would you have if you didn't have someone like Jim Knickman on your side, even he is limited by the availability of information?

If there is no information, there is no competition on the basis of the metric that matters, which is how good you are in delivering value for money. The problem with health care is that third parties are the buyers. In our consumer-driven sectors such as cars, retailing, and computers, consumers are the buyer, so the solution is consumer-driven health care.

In my consumer-driven system, everyone would have to buy health insurance. Is there a system like this anywhere? Yes, in the non-wacko country of Switzerland. If you're Swiss, you must buy health insurance. But you can freely choose from a wide variety of policies, including a [low-cost] one offering a high deductible. There is no Medicaid in Switzerland, so poor people are not stuffed into a program in which up to 40 percent of providers will not give them care because the system pays so badly. In Switzerland, the poor buy health-insurance policies, just as everyone else does.

Providers in the United States are terribly constrained from being innovative by two sets of regulations. One of them is the Stark Law, a large set of laws that restrict the ability of physicians to invest in certain ventures. The reason for the Stark Law is that physicians who invested in their own radiology or laboratory facilities were shown to over-refer their patients to those facilities. The law, named after Congressman Pete Stark, was very well intentioned, but it is the wrong solution. The right solution is transparency and consumer control, not constraining the very people who can be the most innovative.

The second kind of constraint that the federal government places on providers—the Swiss do it, too—is setting prices. Can you imagine what would happen if the federal government set food prices or clothing prices? It not only sets prices for health care but tells you what it will pay for. So if you're a doctor with an innovation that doesn't have a code, you are not going to get paid for it. This essentially blocks out all innovation in our system—except for the brilliant innovators we heard about here. But there is one difference between the Swiss and us: they have universal coverage and buy their own health insurance. In Switzerland, no employer is buying, no government is buying, and it is totally consumer-driven.

What is the result? Excellent quality of care. I do not compare Switzerland with the U.S. because the U.S. is so diverse. I compare it with the state in the U.S. that is the Switzerland of the U.S. What is it?

AUDIENCE: Pennsylvania.

REGINA HERZLINGER: That's good. Anybody else?

AUDIENCE: Utah.

REGINA HERZLINGER: Utah is too poor. Switzerland is a rich country.

AUDIENCE: Connecticut.

REGINA HERZLINGER: Connecticut is number one [in wealth]. The Swiss have much better levels of care even than states similar in [degree of] diversity and other things that determine the quality of care. Yet they spend 40 percent less than we do in the U.S. We spend $2 trillion on health care. That's the GDP of China. Forty percent of $2 trillion is $800 billion that we could save and still achieve excellent results if we switched into a consumer-driven health-care system.

If I were a healthy woman in my mid-thirties, every insurer would want me because of what is known as the Pareto principle, or colloquially as the 80/20 rule. In health care, 20 percent of the users account for 80 percent of the cost. So, if [ratepayers] like me account for only 20 percent of the cost, all the insurers love me. The top 1 percent in the United States [consume] over $36,000 [worth of health care] every year, and they continue to consume it because many of them have chronic diseases.

What do the Swiss do about this? The Swiss insurance companies have formed a consortium, and they risk-adjust one another. The consortium takes [some of] the profits earned by the insurer that has cherry-picked the healthy versions of me and gives them to the insurer that got stuck with the sick versions of me. The reason I like this solution is that, first of all, it works. Sick people are not barred from the market in Switzerland—in fact, they are desired

by insurers; second, it's a private-sector solution; and third, who knows more about risk selection than insurers?

In the financial markets, the traditional role of government has been to ensure transparency. George Stigler of the Chicago school of economics says that private competition can ensure transparency. The problem is that we don't have any of that in health care. We need a set of laws similar to the securities laws. Health care will never achieve transparency unless the government mandates it—because no doctor or hospital wants to be measured.

Instead, the government sets prices. When the government sets prices, it grossly distorts resource allocation. In health services, we have the buildup of many sectors—cardiovascular, ambulatory surgery, home health—just because the government paid unduly generously for them. When the government pulled back, those sectors collapsed.

The government also sets coverage and benefits and now has a process that it disingenuously calls "Pay for Performance," which tells doctors how to practice medicine. Pay for Performance means that if your doctor follows someone's recipe for how to deliver medical care, he is going to be paid more. But medicine has very little knowledge of the connection between cause and effect. Brilliant doctors are really artists, and that kind of creativity must not be suppressed in an age of revolution in medical practice. I call Pay for Performance "Pay for Conformance."

We have a lot of bad ideas in health care. Another one of them is single payer. I am for universal coverage, but I'd like it to be done through consumers, not through the government. No innovator wants to work in a single-payer system. It's much too risky and much too political. I have a class of eighty students, twenty of whom are MDs, and one out of the eighty goes into health-care services because it's so managed by the government.

Or instead of universal coverage, you place the sick into a high-risk pool that is funded jointly by the state government, the federal government, and health insurers. What's wrong with this idea? First, you have the government running the pool. Second, in the entire U.S., 60 million people, or 20 percent of the population, are sick, and roughly 20 percent of those are uninsured, which is 12 million people. Yet we have only 200,000 people in the high-

risk pools because they're so expensive that the states just won't fund them.

Hillary Clinton proposes public-private competition. She's the only candidate who has come out for universal coverage, but she's going to have the uninsured choose between private health-care plans and public health-care plans, including Medicare and the federal Employees Health Benefit Program. There is nothing wrong with that unless it's not fairly priced. Everybody loves Medicare because for every $8 it spends, it pays $1; the other $7 is paid by the people in this room, and will be paid by our children, our grandchildren, and our great-grandchildren. If Medicare is priced on the basis of an intergenerational transfer of wealth, everyone will fall into Medicare and defect to a single-payer system.

Senator Obama favors picking up the catastrophic health expenses of private employers. The private employers are saying, "Thank you, get rid of that expense," but as a result, the federal government is [in the expensive business of] covering sick people.

Massachusetts has managed competition, which means that a government store offers a choice of government-designed plans. The sell in Massachusetts was that it would take the $2.2 billion that we [already] pay to hospitals to take care of the uninsured poor and give it to the poor people [in the form of insurance]. What happened? The subsidized pool has grown a lot—there are 176,000 people newly insured in Massachusetts, and I'm all for that.

But only 18,000 people have signed up for the unsubsidized, managed-competition part, in which the government store [supposedly] is able to offer cheaper plans through brilliant sub-buying of [health care]. In fact, the plans in the government store are so expensive [because of the extensiveness of the plans' coverage] that only 18,000 people have signed up. In fact, the [state] took forty-three million dollars away from the hospitals and neighborhood health centers.

So where the money comes from is where it has always come from: taxes. Does this government pool have lower costs? If you compare the data on Commonwealth Choice with the data on employers, not really.

What went wrong in Massachusetts? The government became much too involved in designing health-insurance policies. When the

legislature designs an insurance plan, it bulks it up. The hospitals are very powerful, and it's very hard to take money away from them.

There's no way we're going to cover the sick and the poor unless we have universal coverage. We can back-door the cost by taxing the insurance companies, but taxing the insurance companies essentially means taxing the people who have insurance rather than taxing everyone. If we're going to cover sick people—and what is health insurance for, except to cover sick people?—we must either tax everyone or establish an insurance market that subsidizes the poor.

I think that eventually, all people will be required to buy their own insurance using tax-sheltered income, the government will help by giving people money so that they can go out and shop like everyone else, and some real data will be produced. But if we expand demand and don't permit innovation in health care, we are going to be in the same situation as Massachusetts, and our costs will increase because supply is going to remain static and there will be more demand.

AUDIENCE: I'm from the U.S. Steel Pension Fund. My understanding is that the Massachusetts Group Insurance Commission for the last three years has been offering insurance policies to state employees, retirees, and their families that group [medical] specialists into tiers based on their quality and cost and supposedly their success. Could you talk about the potential for grouping not only specialists but hospitals and primary-care doctors into tiers?

REGINA HERZLINGER: Medicare is not permitted to do that. I wouldn't tier them by [specialty], hospital, and so on. I would like to see them tiered [according to patients' medical needs]. Doing so would make purchasing decisions [simpler] for someone who, say, has diabetes and needs fifteen varieties of doctors, a dialysis center, and many kinds of surgical procedures. That way, you're requiring patients to [construct] a network for themselves. It makes much more sense to offer them a couple of diabetes teams accompanied by some outcome data and price data. Tiering in pharmaceuticals has been tremendously effective. Over 60 percent of pharmaceuticals are now generics, and I think that's a good thing.

AUDIENCE: What are your thoughts about federalizing the oversight of health-care insurance as opposed to leaving it to the states, which have balkanized everything?

REGINA HERZLINGER: The space for innovations is the insurance market because it's not very expensive to get into that market. You cannot start your own pharmaceutical company, no matter how wealthy you are. You cannot start your own hospital because we're talking about hundreds of millions—if not billions—of dollars. But you could start your own insurance company. In fact, the two innovators in the high-deductible-policy space were entrepreneurial companies backed by venture capital, and they were just a group of ordinary people.

Connecticut is about the size of Switzerland. Switzerland has ninety health insurers. You can get a lot of innovation within a state market. You don't need a lot of people to have a very successful company.

The problem is that most states set prices for you. There may be very good social reasons for them to do so, but when you use an entrepreneur as an instrument of social policy, the entrepreneur is going to say, "The heck with that! I can't make any money at that price."

Or states can give people permission to buy insurance elsewhere. Senator McCain is going to war on this. But I don't know if he understands the depth of the constitutional and legal battles that he is facing, aside from the economic battle.

The Center for Medical Progress (CMP) is dedicated to articulating the importance of medical progress and the connection between free-market institutions and making medical progress both possible and widely available throughout the world. We encourage the development of market-based policy alternatives to sustain medical progress and promote medical innovation. CMP produces a variety of publications, hosts regular forums, and publishes MedicalProgressToday.com, a web magazine devoted to chronicling the connections among private sector investment, biomedical innovation, market friendly public policies, and medical progress.

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