

## Fresh Thinking Response

by Rep. Jim Cooper<sup>1</sup>

Nov. 25, 2007

Professor Jost did a masterful job of sketching health law but the picture is still ugly. It's not his fault. As he correctly says, "The current American health care system... makes no sense."<sup>2</sup>

Here is a thought experiment to give us an aerial view of the terrain.

### Vertical Views

> **Continents.** If one looks at Earth from space, only continents are visible. Human population density can be observed at night (over developed nations) by electric lights and (over undeveloped nations) thermal images of cooking fires. Human health is affected primarily by poverty, birth control, drinking water, agriculture, insects, and diseases like malaria, dysentery, HIV, and cholera. Law is a luxury. Most people in the world subsist on a few dollars a day.

With jet travel, new strains of human disease move between continents at almost the speed of sound. Ships carry dangerous cargo as well as polluted bilge water. Foreign livestock and environmental practices affect U.S. risk levels, as do immigration, quarantine, harbor safety, and public health laws in the U.S. The greatest mass-casualty event in U.S. history, including all wars combined, was the 1918 flu pandemic.<sup>3</sup> The best defenses against avian flu, SARS, or other diseases (including weaponized diseases) are border security, emergency preparedness, and domestic public health precautions such as prompt incident reporting.

> **Countries.** At perhaps 90,000 feet, one can start to see political boundaries. The U.S. appears to be an outlier even among highly developed nations with its wealth and its widespread obesity. Although there are still pockets of poverty and hunger in the U.S., overabundance of food is a greater problem than scarcity. Since higher incomes produce higher spending on everything, including health care,<sup>4</sup> it is probably not surprising that America spends more on health care than any other nation. Even household pets in the

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<sup>1</sup> I would like to thank Reggie Hill, a 25-year health law attorney at Waller Lansden in Nashville, for his careful review of this paper, and Elizabeth Falcone on my congressional staff for her research assistance. The mistakes are mine alone.

<sup>2</sup> Timothy S. Jost, "Legal and Regulatory Issues Presented by Health Care Reform," Fresh Thinking Paper, November, 2007, p. 7.

<sup>3</sup> See John Barry, The Great Influenza: The Epic Story of the Deadliest Plague in History, Viking, 2004.

<sup>4</sup> See Robert L. Ohsfeldt and John R. Schneider of the American Enterprise Institute (health spending increases at a constant rate of about 8% for every \$1,000 increase in GDP per capita), as quoted in John R. Graham, "The Health Cost Myth," Wall Street Journal, Oct. \_\_, 2007.

U.S. get more health care than do countless people in less-developed nations. The average American dog gets \$492 worth of veterinary services annually.<sup>5</sup>

The 2007 McKinsey Global Institute Report<sup>6</sup> does an excellent job of describing America's relative position in health care among developed nations: big spending and mediocre results. A more optimistic view of U.S. standing can be found in David Cutler's, "Your Money or Your Life,"<sup>7</sup> which happily concludes that we must be getting value for our health dollars, otherwise we wouldn't pay so much for care.

Interestingly, the U.S. system discourages any foreign treatment for U.S. citizens, even if cheaper and higher quality.<sup>8</sup> So far, U.S. protectionism faces little retaliation because many wealthy foreigners still seek treatment here.

**> Repairing Patients, Not Preventing Problems.** At an altitude of 80,000 feet, we can begin to see that the focus of U.S. health spending is on remedial medical care, not on health promotion. We prefer to treat patients, not populations. As Steven Schroeder pointed out in his recent Shattuck Lecture,<sup>9</sup> remedial medical care only shapes about 10% of our health status; other, more important factors are behavior (40%), genetics (30%), and social circumstances (15%). A lesser factor is environmental exposure (5%). U.S. policy seems hopelessly prejudiced against safety, public health, and prevention, depriving federal agencies like the Surgeon General, NHTSA, OSHA, CPSC, CDC, and EPA of their appropriate funding and influence. CMS towers over them all. The Surgeon General's voice has been particularly quiet in recent years. Having warned Americans of the dangers of smoking decades before any legislative action, the Surgeon General and Public Health Service have been marginalized into providing health care for the poor, or offering controversial advice on condom distribution and needle exchanges.<sup>10</sup>

The key role of physicians as decision-makers in the remedial U.S. system cannot be stressed too strongly. These 700,000 people, plus some nurse practitioners with prescribing authority, have the ability to direct vast flows of U.S. health spending without much, if any, supervision.<sup>11</sup> U.S. physicians are becoming more and more specialized instead of practicing preventive or primary care. Tracking their practice variations has been the great achievement of Jack Wennberg and Elliott Fisher,<sup>12</sup> but, to my knowledge,

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<sup>5</sup> Americans spent \$38.4 billion on pets in 2006, almost \$18 billion of which was for veterinary care and over-the-counter medicines. See Consumer Action, April, 2006. For veterinary costs, see Steve Johnson, Doggie.News.com.

<sup>6</sup> See [www.mckinsey.com/mgi/rp/healthare/accounting\\_cost\\_healthcare.asp](http://www.mckinsey.com/mgi/rp/healthare/accounting_cost_healthcare.asp)

<sup>7</sup> David Cutler, "Your Money or Your Life: Strong Medicine for America's Health Care System," Oxford University Press, 2004.

<sup>8</sup> Aaditya Mattoo and Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, Health Affairs, Mar./April 2006, p. 358.

<sup>9</sup> Steven A. Schroeder, M.D., *We Can Do Better – Improving the Health of the American People*, New England Journal of Medicine, 357:12, p. 1221, Sept. 20, 2007.

<sup>10</sup> Hearing, "The Surgeon General's Vital Mission: Lessons for the Future," Committee on Oversight and Government Reform, July 10, 2007.

<sup>11</sup> See Alain Enthoven, "Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System," Committee for Economic Development, Nov. 2007, Appendix B, p. 70.

<sup>12</sup> See Dartmouth Atlas of American Health Care.

only the consulting service IMS has begun to plumb referral patterns (and its data are used to exploit, not improve, the system). The central issue in U.S. health reform is whether physicians can or should retain their autonomy. My guess is that they can do so if they can dramatically improve their professionalism.

Two of the most important words in U.S. health law are “medical necessity.” These words are usually interpreted defensively to give physicians broad discretion to determine appropriate treatment,<sup>13</sup> but they could have been interpreted offensively to allow physicians to promote public health or preventive care. In Chinese tradition, doctors were paid only while patients were well, not when they were sick. Only the most aggressive HMOs focus doctors’ attention on encouraging healthy lifestyles, instead of just repairing the damage.

Promoting wellness is more popular with segments of the public than with policymakers. Alternative medicine, dietary supplements, organic food, health clubs and exercise equipment are hugely popular in the U.S., purchased with out-of-pocket funds, and lightly regulated. (So is cosmetic surgery.) In addition, more employers are focusing on either wellness promotion, or at least penalties for unhealthy behavior, in order to increase productivity and lower absenteeism.

The growing movement to promote higher-quality health care is more targeted to reducing errors in remedial medical care than on promoting wellness. The landmark IOM study, “To Err Is Human,”<sup>14</sup> cited up to 100,000 annual deaths from preventable medical error, sparking greater efforts for health workers to wash hands, write clearly, label medicines, and other obvious steps. Earlier diagnosis of diabetes and strict control of blood sugar require more advanced efforts. Reducing body mass indices is yet a further step on the way to a healthier nation.

> **Funding the Repairs.** At 70,000 feet we can begin to see aggregate flows of health care dollars, spent almost exclusively for remedial care. These flows are massive: 16% of U.S. GDP and rising, a far larger percentage than in any other nation. Paul Starr’s famous truism is that American medical spending equals health incomes<sup>15</sup> or, at today’s levels, \$2.1 trillion = \$2.1 trillion. He meant, of course, that all the money spent on medical care creates vested interests, none of which admits that there is any waste in the system. At this altitude, it really makes no difference if the U.S. system were nationalized, single-payer, or in its current state of confusion; none of the recipients of funds wants to be cut. From a legislative standpoint, this means that any change in current law faces a barrage of lobbying opposition.

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<sup>13</sup> See James Blumstein, Vanderbilt Law School, whose pioneering efforts to define “medical necessity” in the context of Tennessee’s Medicaid waiver program, TennCare, deserve national attention.

<sup>14</sup> Linda T. Kohn, Janet M. Corrigan, Molla S. Donaldson, “To Err Is Human: Building a Safer Health System,” Institute of Medicine, Committee on Quality of Health Care in America, Academy Press, 2000.

<sup>15</sup> Paul Starr, The Logic of Health Reform, Whittle Direct Books, 1992, p. 12. Of course, when Starr wrote it, the U.S. was only spending \$1.4 trillion on health care.

Funding repairs of anything should make us think of the value of the broken item. Depreciation is the conventional way of preparing for such expenses. But with humans, the value of life is a touchy subject. Of course it's priceless to the individual who is impaired, but taxpayers and premium payers don't want to pay more. Eventually, there will be a serious debate on these issues, probably using Kip Viscusi's research,<sup>16</sup> but the time is not yet ripe.

It is worth noting that the U.S. relationship with neighboring countries is largely insignificant. Canada offers a long border with cheaper medicines and good primary care, while Mexico barely regulates drugs and medical procedures. Other than the "war on drugs" against illegal narcotics, the main evidence of cross-border friction is found primarily in congressional proposals for "reimportation" of Canadian medicine. U.S. pharmaceutical companies object to reimportation, claiming widespread counterfeiting of medicines that appear to be packaged like American prescription drugs. The whole debate is a sideshow for the real issues of government bargaining power and U.S. subsidies for research that eventually benefit all nations.

Surprisingly, the U.S. has been greatly dependent on foreign medical graduates from outside the hemisphere to augment its physician force. The creation of more residency slots in the 1980s without an increase in graduation rates from U.S. medical schools created opportunities for thousands of FMGs to practice here, particularly in poorer areas. With so many U.S.-trained physicians seeking specialist positions, and with allopathic medical schools refusing to grow, this influx of foreign-trained doctors may need to continue in order to fill shortfalls in primary care practices.

> **Adding a Middleman: "Insurance"**. At 60,000 feet, we can see that our exaggerated focus on remedial medical care is funded indirectly, with insurance. Much of Professor Jost's paper involves complexities caused by insurance. The U.S. preoccupation with insurance can be explained due to its popularity as a "tool of government"<sup>17</sup> with politicians, who often conflate "health insurance" with "health care." In many ways insurance is the perfect benefit for politicians:

- "Health" insurance offers voters peace of mind when they are well, and lower medical bills in the event of sickness or injury;
- Like a magician's sleight-of-hand, insurance distracts the beneficiary from the missed opportunity to have remained healthy by avoiding the sickness or injury;
- Insurance confers status on voters without painful self-discipline like diet, exercise, safe driving, or curtailing smoking or drinking,
- It absolves politicians from taking responsibility for voters' poor choices with insurance proceeds, whether in lifestyles, care providers, or treatment options;

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<sup>16</sup> See, e.g., W. Kip Viscusi, "Misuse and Proper Uses of Hedonic Values of Life," Olin Center, 2000.

<sup>17</sup> See Lester Salamon, ed., The Tools of Government: A Guide to the New Governance, Oxford Univ. Press, 2002.

- The price tag of an insurance benefit is hard to see,<sup>18</sup> and often kept hidden by politicians, so few people are alarmed, offended, or held accountable;<sup>19</sup>
- It is easier to keep supplying 85% of Americans with medical insurance than it is to provide higher median incomes, higher levels of education, or other benefits that would do more to improve health status;
- The 15% of the population without health coverage never complain enough to get coverage or to defeat politicians who refuse to reform the system;
- It is easier for politicians to keep promising “universal coverage” than “universal health care” because it is more attainable;
- Insurance stimulates demand for the services of several powerful professions and industries, which often show their appreciation in the form of campaign contributions;
- Traditional indemnity insurance preserved the complete autonomy of health professions (now partly superseded by PPOs and managed care),<sup>20</sup> and
- Even government health insurance shows great deference to private-sector payors like fiscal intermediaries and carriers.

Health insurance is so popular with politicians that it is today’s “opium of the masses.”<sup>21</sup> Insufficient enthusiasm for private health insurance is usually derided as a preference for “socialized medicine,”<sup>22</sup> because it would mean that the government would be pooling risk and paying physicians or other health providers directly. Even if this were cheaper and better, it is widely considered taboo, particularly by physicians (although they might be its primary beneficiaries).

*Timeout for a micro thought-experiment: Imagine the government paying doctors and hospitals directly at the same level of compensation they earned last year, only without any paperwork. These health providers would have to pledge that they would take all patients, or as many as they could handle. Such a “system” would probably break down quickly due to shirking, but it could save hundreds of billions of dollars in the meantime. If such a paperless single-payer system continued, adjustments would*

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<sup>18</sup> Insurance has three visible prices: the premium (which hides the “load” or sales charge, which can be as high as 45% for small businesses), and the deductible and copay or coinsurance (the “out-of-pocket” cost of health insurance). Since employers “pay” for the majority of the insurance premium for the employee (although this is, over time, taken from the employee’s foregone pay raises), the employee only notices the full premium in the event he or she loses their job and is offered COBRA coverage at 102% of the total premium, which often seems like a four-fold price increase to the employee who was accustomed to paying 25%.

<sup>19</sup> See H.R. 847, introduced by Rep. Jim Cooper in the 110<sup>th</sup> Congress, to require that W-2 forms include the amount of employer-sponsored health insurance annual premium, a number that is not recorded on any official piece of paper in the employee’s life.

<sup>20</sup> See Enthoven, *supra*.

<sup>21</sup> “The post-war history of U.S. health care finance has been, in an important sense, all about health insurance. The rise of insurance financing in the public and private sectors has been a major driver of increased access to services. In comparison to the 1945-1965 period, when public sector efforts were focused primarily on increasing supply, the past forty years have empowered demand, by shielding the insured population from all but a fraction of the cost of the services it receives. Our failure to so endow a sizeable share of our citizens continues to be held up as a major failure of health policy.” Moran, Donald W., *Whence and Whither Health Insurance? A Revisionist History*, Health Affairs, Nov./Dec. 2005, p. 1419

<sup>22</sup> See Paul Starr, *The Social Transformation of American Medicine*, Basic Books, 1982.

*have to be made according to each provider's diligence and expertise. Sadly, paperwork would return, but this thought experiment focuses our attention on the fact that the U.S. Government is a probably a much more efficient mechanism for pooling risk, judging performance, and paying providers.*

> **Confusing the Middleman: Savings.** At 50,000 feet, you start noticing that most of American health insurance is often just a tax-favored form of savings that is disguised as insurance. Since low-cost sickness and injury are so common, they are “uninsurable” at rates that are considered affordable, yet people demand policies anyway. Conversely, very expensive hospital stays are so rare that these are insurable (or they have been since the 1930s, when American health insurance was invented). Properly understood, American health insurance is really a hybrid of a forced savings plan for normal health care expenses, with a catastrophic insurance backup (although Medicare and private health insurance policies provide less backup than many people think). The very nature of American health insurance involves this internal cross-subsidy. Most people, even the highly-educated, think that “good” health insurance involves very low co-pays and deductibles, and most politicians love catering to such beliefs. Some first-dollar coverage still exists, particularly for union members, because its true cost can be so well hidden. But top corporate executives also get first-dollar coverage, regardless of the formal terms of their health policies, because of board reimbursement of out-of-pocket expenses.<sup>23</sup>

Republicans have pushed various forms of “health savings accounts” to promote personal savings for routine medical expenses, sometimes with the savings gained from the lower premiums of high-deductible policies. Due to the unpopularity of saving for medical care, however, only a few million people have chosen such plans. The Employee Benefits Research Institute estimates that HSA savings incentives are too small to be realistic.<sup>24</sup> Only employees who contribute the maximum for 35 years and who never withdraw any funds will have saved enough to pay for their retiree medical bills.

In addition to mixing insurance with savings mechanisms, an increasingly popular type of health insurance combines insurance with a lottery concept. “Dread disease insurance” or “cancer coverage” is offered to many group health beneficiaries. Pioneered by AFLAC, it covers only the specific disease by supplementing existing health coverage. If you contract a different type of illness, however, there is no benefit. Policyholders either purchase the coverage due to visceral fear of a particular illness, or

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<sup>23</sup> Reinhardt, Uwe E., *Is There Hope for the Uninsured?*, Health Affairs Web Exclusive, Aug. 27, 2003, p. W3-386.

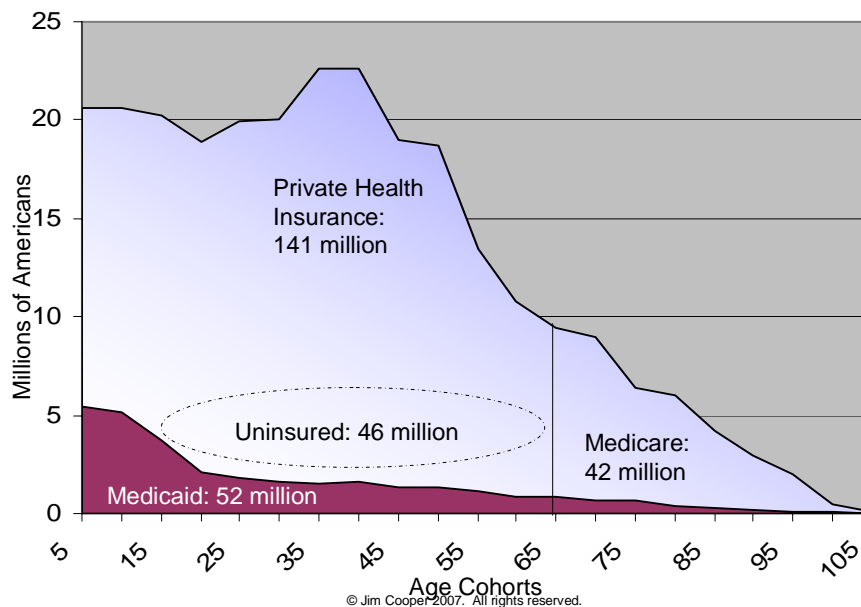
<sup>24</sup> “An individual age 55 who lived to age 80 would need to have accumulated \$230,000 (by age 65 in 2015) to pay for out-of-pocket medical costs, including premiums for employment-based health benefits for supplement Medicare. If that same individual contributed the maximum allowed by law to an HSA and never made any withdrawals, the accumulation would total \$48,000 after 10 years of maximum contributions – far below the \$230,000 needed.” Paul Fronstin, EBRI Notes, Aug. 2005, p. 7.

play the odds. Attempts to study the medical loss ratios of such products at the federal level have been stymied by industry.<sup>25</sup>

The innovativeness of private-health-insurance marketing is amazing. Recently a Texas company began offering health coverage to people immediately after they become sick, but charging appropriately high premiums.<sup>26</sup>

> **Dividing Insurance Programs.** At 40,000 feet we can see the names of the major “health” insurance programs. Surprisingly, what matters most is your geographical location at the time of injury or illness. For example, auto insurance covers traffic injuries, workman’s compensation covers problems on the job, and your neighbor’s homeowner’s insurance covers your slip-and-fall injury at their home. Sometimes, your prior location is determinative: if you are a military veteran who was injured while serving then you can access the highest-quality health system in America, the VA hospitals, depending on eight levels of service-related priority.

## The 4 Major Payment Systems



If you are not injured on the road, job, neighbor’s house, or military base, then there are four major programs that become your primary insurance payor: Medicare (\$429 billion in 2007),<sup>27</sup> Medicaid (\$336 billion, including federal and state shares), the

<sup>25</sup> The author attempted to obtain a GAO report of industry practices when he served on the Energy and Commerce Committee in the early 1990s, but his amendment was removed in conference at the behest of industry.

<sup>26</sup> Wall St. Journal, Sept. 14, 2007, p. B1.

<sup>27</sup> The unusual spike in Medicare costs is due to the Medicare Modernization Act of 2003, which added a Part D drug benefit to the Medicare benefit package.

federal tax breaks for employer-sponsored health insurance (\$200 billion), and the hodge-podge of programs for the uninsured<sup>28</sup> (\$70 billion?).

Professor Jost was correct to note that the tax subsidies for private health insurance are, in fact, America's third largest health program, but one that is largely unmonitored by policymakers and unmentioned even in most health care textbooks. I go even farther to include the various programs for the uninsured as America's fourth largest health program because Congress cannot deny that it has allowed policy Band-Aids (like DSH, EMTALA, DME, and IME) to become a *de facto* federal policy on the uninsured.

The tipping point has been reached; government-funded and subsidized payments account for the majority, roughly 63%, of total U.S. health spending, while private insurance accounts for only 37% (although private corporations implement even the government insurance).

Although Medicare accounts for roughly 20% of total U.S. health spending, it sets many standards for the other insurance programs because it is the only program that can effectively compel physician behavior (due to 98% of doctors taking "assignment"). This suggests that health care reform must contain provisions that wrest control of the U.S. health care system from Medicare, if genuine change is to occur. Conversely, Medicaid is the least influential program on physician behavior because between one-third and two-thirds of doctor's refuse or limit their number of Medicaid patients (a problem that the current SCHIP debate is not addressing).

These major government programs offer or subsidize a surprisingly narrow type of insurance: reimbursement for medical expenses only, and of the remedial kind. We are so accustomed to this type of insurance that we fail to realize that disability insurance can offer more complete protection from, for example, illness or injury. Disability benefits can be used to pay for anything: medical care, living expenses, etc., but are usually not rich enough to cover very expensive medical treatment. Conversely, some people with excellent medical insurance find their hospitalization paid, but with little left to live on. The fact that 15% of Americans lack health insurance is seldom compared to the fact that 78% lack disability coverage.<sup>29</sup>

> **Quirks of the Insurance Programs.** At 30,000 feet, if we look closely, we can see many oddities of today's health insurance market:

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<sup>28</sup> Although textbooks omit any program for the uninsured, it seems to the author that it is fair to call the decades-long response by the federal government to a growing problem a program, no matter how fragmented. Federal DSH payments and other programs can even compensate hospitals for 85% of their "uncompensated" care expenses, which is higher reimbursement than for some Medicaid procedures. See Hadley, Jack and Holahan, John, "The Cost of the Uninsured," Kaiser Commission, 2004, p. 4.

<sup>29</sup> It is possible that one of the hidden benefits of Social Security, a disability policy worth as estimated \$300,000, has reduced demand for privately purchased coverage.

- private health insurance cross-subsidizes every government payor, but particularly Medicaid; meanwhile private insurance usually apes Medicare's policies;
- two-thirds of physicians are, in effect, on strike against seeing Medicaid patients due to low reimbursement;
- no one really knows how much it costs to determine Medicaid eligibility, collect premiums, copays and deductibles, or determine primary and secondary payors for Medicare, Medicaid or private insurance;
- in fact, no one really knows what anything "costs" in health care because the word means, in the health context, "what you have gotten away with charging;"
- one-year medical policies prevent insurers from taking a long-term view of patient health by promoting wellness;
- there are many holes in coverage by medical policies (dental care, eye care, nursing home care, etc.);
- the people who need it least get the largest tax subsidies for health insurance: high-wage employees of large companies;
- tax credits for the purchase of insurance are dreadfully inefficient;<sup>30</sup>
- fee-for-service medicine is fostered by insurance, a style of practice that is a professional conflict of interest for physicians (like paying lawyers by the word!);
- delays in insurance payment (particularly from the private sector) give health providers the oldest accounts receivable of any business; and
- no one wants to pay for research, graduate medical education, or for computerization of physician offices.

Furthermore, the complexity of health law (primarily due to private insurance) challenges the fundamental legal principle that everyone is presumed to know the law or, conversely, that ignorance is no defense. This creates a "Tower of Babel" health system.

One of the major insurance confusions is due to federalism. In theory, insurance is regulated at the state level but, in practice, the power of the insurance companies is so great that they face little or no regulation. For example, in Tennessee, the largest insurance company is completely exempt from scrutiny, not only in practice but by law. In Congress, no committee has true jurisdiction over insurance after the McCarran-Ferguson giveaway in 1946. This is a particularly ironic, and perhaps tragic, oversight since, in Peter Fisher's phrase, "Think of the federal government as a giant insurance company (with side line business in national defense and homeland security)"<sup>31</sup> that is \$50 trillion in the red. Literally no one in Congress is qualified to examine the "black box" of insurance that comprises most of federal government.

Another major quirk in American health insurance is that no one but economists really knows where the money is coming from. (Even economists have trouble, as Victor Fuchs demonstrated when he tested his fellow economists during his tenure as President of the AEA.) Our system of employer-sponsored health insurance leads many to think

<sup>30</sup> See Leonard E. Burman and Jonathan Gruber, "Tax Credits for Health Insurance," Policy Briefs/Tax Policy: Issues and Options, Urban Institute, June 23, 2005.

<sup>31</sup> Speech by Peter R. Fisher, former Bush Administration Undersecretary of Treasury, 2003. Peter is now a principal at Blackrock, the mutual fund company, in New York, and is the brother of Elliott Fisher.

that employers are paying for employee health insurance, but they are not. Instead, they are taking employees foregone pay raises and paternalistically using them to purchase health insurance coverage, usually at inflated prices. Little wonder that median cash wages have remained virtually stagnant while fringe benefits have soared. This tax subsidy “pump” has flooded health industries with dollars in amounts that other sectors of the economy cannot even imagine. The UAW effort to purchase GM’s VEBA plan could prove to be a cold, hard lesson in managing health benefits because the UAW will not have use of this pump.

Finally, the basic business unit of American health care, the physician’s office in a small group or solo practice, is probably the most undercapitalized type of firm in the U.S. Since physicians are accustomed to withdrawing virtually all their profits at year-end, there is little money left for investment in capital improvements, even for electronic medical records. The health sector is one of the least computerized in the U.S., and is demanding government subsidies (not just standard-setting) before it modernizes. This leads us to another source of confusion: the role that hospitals play in our system. Robert Clark has argued that they are little more than cooperatives run for the benefit of physicians with hospital privileges.<sup>32</sup>

**> Parachutes Don’t Work?** At 20,000 feet, we notice that, despite the uneven and quirky nature of health insurance, it has had a vastly stimulative effect on demand for health services. In order to dampen this artificially-inflated demand for health spending, a long series of legal reforms have been attempted, none successfully. According to Alain Enthoven’s latest list, these may be characterized as 1) waste, fraud and abuse, 2) certificate of need, 3) price controls, 4) voluntary effort, 5) PSROs, 6) PROs, 7) HMOs, 8) PPS, 9) competition, 10) RBRVS, 11) managed care, 12) consumer-directed health plans, 13) Medicare-for-all, 14) IT, 15) electronic health records, 16) pay-for-performance, 17) disease management, 18) evidence-based medicine, 19) tort reform, 20) tiered high-performance networks, and 21) transparency.<sup>33</sup>

Traditional and widely used brakes such as copays and deductibles have multiple problems: they discourage worthwhile preventive care, and they are ineffective for the 80% of health costs incurred after the deductible has been met. HSAs and high-deductible plans exacerbate these problems while creating the illusion that reform is occurring.

This pattern of over-stimulating demand v. crude braking mechanisms is reflected in all major insurance programs. Private health insurance inflates the worker’s health dollar into roughly \$7.20 of medical care.<sup>34</sup> Medicare offers far richer benefits than the

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<sup>32</sup> Robert Charles Clark, “Does the NonProfit Form Fit the Hospital Industry?” Harvard Law Review, Vol. 93, No. 7, May, 1980, p.1416.

<sup>33</sup> See Enthoven, pp. 22-31.

<sup>34</sup> Since employees typically pay 25% of health insurance premiums, the employer match allows the employee’s \$1 contribution to have the purchasing power of \$4. High-income employees can get up to a 50% tax subsidy, increasing purchasing power to \$6. Private health insurance pays providers 120% of cost, raising the purchasing power to \$7.20.

current payroll tax can fund.<sup>35</sup> Medicaid has been gamed so thoroughly by the states that a 2-1 match can become 8-1.<sup>36</sup> The new SCHIP program will start at almost 4-1.<sup>37</sup>

Government reimbursement is often both overly generous and poorly policed, but also carries with it draconian criminal and civil penalties if offenders are caught. It is not much of an exaggeration to say that the medical profession as well as hospital administration has been criminalized<sup>38</sup> because so many penalties are felonies or misdemeanors. Just the threat of sanction is compelling. An increasing number of prosecutions today result in “deferred prosecution agreements” or “corporate integrity agreements” which give the Justice Department almost permanent control over defendants without admissions of guilt.<sup>39</sup> This undermines the fundamental legal principle that you are innocent until proven guilty.

Surprisingly, the severity of penalties has not deterred pharmaceutical companies in particular from what may be called “business plan fraud” since they have paid over \$5 billion in fines in the last ten years, many for repeated violations. A backlog of 180 cases, worth an estimated \$60 billion in additional fines, is already pending before the Justice Department.<sup>40</sup> Another curious feature of these enforcement actions is that many of the crimes are statistical, since the volume of health care transactions is so great. In other words, there is no injured party who is identified by name or compensated for his or her injury, only (one hopes) a statistically-robust correlation that “proves” wrong-doing. Data-mining could probably put every physician in America in jail. And, as Malcolm Sparrow pointed out in License to Steal,<sup>41</sup> the sanctions against fee-for-serve care were designed to prevent overutilization, whereas the penalties against managed care were intended to prevent underutilization. Sometimes the wrong penalties are applied to the health crime.

> **Serious Soul-Searching: Free-Lunch Mentality.** At 10,000 feet, it becomes clear that many of the systems problems are caused by us, not policies or politicians. Although health care is not a right in America (except for prison inmates), people are increasingly demanding free, or nearly free, health care. Out-of-pocket expenditures for care have plummeted since the 1960s. Elizabeth Warren’s study of health-care bankruptcy indicated that the average health bill that leads people into bankruptcy is only \$3,686,

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<sup>35</sup> Medicare’s Part B and D programs offer a general revenue match of 3-1 and 4-1, inflating beneficiary contributions from \$1 to \$3 or \$4.

<sup>36</sup> States have been able to obtain provider donations, provider taxes, and intergovernmental transfers in order to receive more federal dollars under the state’s FMAP percentage, which ranges from 50% to 70%.

<sup>37</sup> The higher FMAP percentage of roughly 80% for SCHIP that was established in 1997 is proposed to be continued under pending congressional legislation.

<sup>38</sup> As Uwe Reinhardt has written in the Wall St. Journal, “Medicare Can Turn Anyone into a Crook.”

<sup>39</sup> Epstein, Richard A., “The Deferred Prosecution Racket,” Wall St. Journal, Nov. 28, 2006, pointing out a case in which the prosecutor forced Bristol Myers Squibb to endow a chair of ethics at the prosecutor’s law school alma mater.

<sup>40</sup> Hearing, “Financial Impacts of Waste, Fraud, and Abuse in Pharmaceutical Pricing,” Committee on Oversight and Government Reform, Testimony of Ronald J. Tenpas, Feb. 9, 2007.

<sup>41</sup> Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America’s Health Care System, Westview Press, 2000.

after an episode of illness of \$11,854.<sup>42</sup> So, for less than the price of a used car, people in America go to court to get out of paying their medical bills. Not even student loans are regarded as such dispensable obligations.

The federal government also has a free-lunch mentality when it fails to account for Medicare and Medicaid spending, even though, as Jost ably explains, both programs are, in varying degrees, “entitlements.” Because the federal government is the last large entity in America allowed to use cash accounting, only immediate payments by Medicare are recorded on the national financial statements. In fact, Medicare does not look like a legal entitlement if you are only looking at U.S. financial statements.<sup>43</sup> Today’s government accounting treatment reduces Medicare’s benefits below liabilities, below obligations, below even promises, to “scheduled benefits” which are only one step above wishful thinking. Medicare payments are only booked when “due and payable,” not when the beneficiary has a) paid 40 quarters of payroll tax, b) turned 65, and c) left his company health insurance plan. One might think that “vesting” had occurred at one of these earlier points; in fact, the Federal Accounting Standards Advisory Board has voted 6-4 to implement a 40-quarter standard. But it has been unable to produce a final policy due to the budget-shaking implications of adding tens of trillions of “liabilities” to the national balance sheet (if only for planning purposes, not for retroactively granting Medicare beneficiaries contractual rights to their benefits). The rest of Peter Fisher’s phrase regarding the federal government goes like this: “Think of the federal government as a giant insurance company... which only does its accounting on a cash basis – only counting premiums and payouts as they go in and out the door. An insurance company with cash accounting is not an insurance company at all. It’s an accident waiting to happen.”

As for Medicaid, a looser entitlement program, the federal government lacks the means to do more than estimate future obligations based on past growth rates. So Medicaid is also largely omitted from government financials, although for more innocent reasons. To compound the problem, the federal government is also unable to analyze or accurately record the effect of tax expenditures, which are the ultimate entitlement. Tax expenditures face no restraints: on their costs, guidelines or regulations. We can only guess as to their budgetary impact. As a Bush Treasury official testified, such programs are “unmeasured and unmeasurable, unverified and unverifiable.”<sup>44</sup>

> **Bankruptcy.** You hit the ground very hard because you didn’t see it coming. You were the only one who didn’t because your eyes were closed. According to the U.S. Government’s only audited numbers, using accrual accounting, Medicare is \$32 trillion

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<sup>42</sup> David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, Health Affairs, Web Exclusive, W5-63, February 2, 2005. Disputed by Dranove, David, and Millenson, Michael L., *Medical Bankruptcy: Myth Versus Fact*, Health Affairs Web Exclusive, Feb. 28, 2006, p. W74, and also the rebuttal by Himmelstein et al., *Discounting the Debtors Will Not Make Medical Bankruptcy Disappear*, *ibid.* p. W84.

<sup>43</sup> Or at the 1960 U.S. Supreme Court decision in Fleming v. Nestor, which held that Congress can change Social Security benefits at will.

<sup>44</sup> Testimony of Pam Olsen, Assistant Secretary of Treasury for Tax Policy, House Budget Committee, 2003.

underfunded on a present value basis, Medicaid is probably equally insolvent, and the rest of government probably has obligations of \$18 billion. This means that the federal government is at least \$50 trillion in the hole, not counting Medicaid.

Standard & Poors has already projected that, if current health spending continues, that the Treasury bond will lose its AAA rating by 2012, be on par with Estonia by 2015, fall to Mexican levels by 2020, and plummet below investment grade by 2025. The only reason it is not a prediction is that S&P assumes that politicians will intervene in time.

The fear here, as Howell Jackson estimates,<sup>45</sup> is that our entitlement obligations are accumulating at the rate of \$3 trillion to \$4 trillion annually. Since our antiquated political system requires at least a year to pass a major law, any reform proposal would have to save *more than* \$3 to \$4 trillion in order to get ahead of the mounting problems. No one has proposed reforms of that size, therefore the fiscal problem may be irreversible at this point.

### **Horizontal View**

Turning toward a more conventional analysis of “Law and Regulation,” here are a several gap-fillers that may complete Professor Jost’s analysis.

### **Other Types of Laws**

There are two categories of rules that Professor Jost could have stressed: unwritten laws, and policies resulting from mass litigation.<sup>46</sup>

Unwritten laws include:

- the growing U.S. social understanding that medical expenses should not be allowed to exceed 5% to 7% of personal income;<sup>47</sup>
- the tax breaks for employer-sponsored health insurance that, with the possible exception of congressional ratification in the tax code of 1954, have burgeoned beyond the intent of any policymaker, becoming the third largest federal health care program;
- the fact that federal accounting policy is: “Uncle Sam would prefer that Medicare beneficiaries die unexpectedly so that no book entries have to be made on federal financial statements;”
- the tacit U.S. ban on people dying in the street which, with the exception of homeless people on cold nights, usually prompts just enough response

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<sup>45</sup> Howell E. Jackson, “Accounting for Social Security and Its Reform,” Harvard Journal on Legislation, Winter, 2004.

<sup>46</sup> See W. Kip Viscusi, Regulation Through Litigation, AEI/Brookings Press, 2002.

<sup>47</sup> Lambrew, Jeanne M., Podesta, John, and Shaw, Teresa L., *Change in Challenging Times: A Plan for Extending and Improving Health Coverage*, Health Affairs Web Exclusive, March 23, 2005, p.W5-122.

at the local, state, or federal level to provide “health care” to keep this misery from public view; and

The classic example of policy resulting from litigation is tobacco regulation which was politically impossible until the courts intervened to force the settlement on the major U.S. cigarette manufacturers. This has freed Congress to consider the previously unthinkable – FDA regulation of tobacco – but also, not surprisingly, to spawn the creation of new cigarette companies which are not bound by the settlement. Other policies resulting from litigation are the hidden premiums in pharmaceuticals due to their penchant for “business plan” fraud.

### **Non-Profit Boards**

One little-noticed problem with the supply of U.S health care is the control of 85% of hospitals with non-profit boards of directors. These boards are usually comprised of community leaders with little or no experience in health care. Unlike corporate directors who are exposed to shareholder lawsuits, non-profit board members are insulated from liability. Although this protection may be well-intended, its practical effect is to delay or terminate any effort by non-profit directors to learn the business of their hospital or the health care environment. To have a key choke point of the U.S. health care system controlled by a regular supply of semi-competent people is a major problem.

Fortunately, efforts are being made to solve this competency problem with new federal aggressiveness in questioning hospitals’ tax exemptions (particularly by the Senate Finance Committee under Sen. Charles Grassley), using the False Claims Act against billing for poor quality services, and with a new white paper entitled, “Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors.” It is too early to tell whether the culture of these boards can be changed.

### **Medigap Abuse**

Although supplemental insurance for Medicare is a very popular type of coverage, it creates major problems that even the trade association for Medigap providers admits are real. Congressional regulation of the industry forced each company to offer one or more of a limited range of policies, A-J, but the common denominator of each is to reduce or eliminate the copays and deductibles of the main Medicare benefit. This type of insurance is predatory on the Medicare program because it raises total Medicare costs by as much as 30% by weakening Medicare’s own braking mechanism on beneficiary spending. Medigap insurance is also extremely profitable to the insurance companies, because their liability is limited to little more than the copays and deductibles. Medical

loss ratios are usually kept above 65%, but could easily fall below 50% without regulation, making Medigap one of the most lucrative types of insurance.<sup>48</sup>

When confronted with these arguments, the trade association for these Medigap insurance companies, the American Health Insurance Plans, denied any problems and offered to submit their defense in writing. Their own draft document admits, however, that current Medigap policy raises total Medicare costs by 14%.<sup>49</sup> This percentage of \$429 billion is roughly \$60 billion annually! This admission by AHIP is almost an engraved invitation to terminate the current Medigap program, and to replace it with Medigap insurance that is not predatory to Medicare, but offers seniors valuable preventive care and catastrophic coverage.

### **Role of Blue Cross/Blue Shield**

These companies, which largely founded the health insurance industry, and which still have a near-monopoly position in the individual insurance market, receive \$1 billion annually in tax expenditures from Congress. Neither Congress nor BC/BS have been able to identify the purpose or use of this tax expenditure.

### **Role of Physicians**

Physicians are prevented from being employees in many states due to bans on the corporate practice of medicine. Physician practice management companies tried, ultimately unsuccessfully, to contract with physicians as independent contractors or professional service corporations for long-term service agreements of 20 to even 40 years duration.

Another way of affecting physician behavior has been to allow physician investments in hospitals, specialty hospitals, out-patient surgery centers, diagnostic centers, labs, and imaging equipment and other medical technology. These investments often increase the investor/physician's referrals to those facilities, although the Stark I and II laws attempt to limit abusive referrals. The McKinsey study estimated that U.S. physicians supplement their incomes by \$8 billion annually due to such investments.

Although physicians have traditionally been barred from selling medicines, thereby separating doctors' offices and pharmacies, they are able to offer free samples to selected patients courtesy of pharmaceutical companies. Estimated at a market value of \$14 billion annually, these samples are a powerful perk for doctors, as well as a not-so-subtle encouragement to start using the brand-name drug that is being sampled. Some physicians are able to resell drugs on premises, contrary to the general ban on physicians

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<sup>48</sup> Another very lucrative type of insurance is the burial coverage that is still offered in low-income neighborhoods, exploiting the fear of the pauper's grave. See Starr, p. 242.

<sup>49</sup> AHIP, "*DRAFT: Medigap Coverage and Medicare Spending, A Second Look*," 27 pages, plus Exhibits. Hand-delivered to author, Spring, 2007.

reselling medicine. Oncologists may earn as much as 75% of practice income from such sales, and not from conducting medical procedures. The Bayer company was fined for raising prices in order to increase physician purchases of its chemotherapy, because the physicians were able to make more money by reselling the more expensive medicine.

Physicians are so fractious that no medical organization represents more than a small fraction of them. The American Medical Association is the largest, with roughly 30% of physicians as members, although most are passive participants. Even the AMA would have a difficult time surviving if it did not receive \$40 million annually from trademark royalties on CPT codes, a way of benefiting from the practices of all physicians, even those who refuse to join the AMA.

### **30 Second Pharma Ads**

Since 1998, pharmaceutical companies have been allowed to advertise on television, creating a new \$5 billion source of revenue for broadcasters. The power of TV ads has motivated countless patients to learn about new diseases and treatments, but also to prevail upon their physicians for a prescription, whether or not the medicine is appropriate. Often the spoken warnings on the ad are unheeded by patients (“may cause diarrhea, vomiting...”), and sometimes even purpose of the drug. The \$5 billion is creating a lot of “30-second physicians” who are increasingly demanding with their doctors. It is ironic that \$5 billion approximates total national subsidies of graduate medical education.

### **Conclusion**

It has been a privilege to comment on Professor Jost’s paper. He left relatively few legal gaps to fill. As we learn about health “Law and Regulation” we should feel free to let familiarity breed contempt.

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