5 ways to solve health care

Between the Supreme Court and Congress, ObamaCare is on the ropes — but there is a better way

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Sometime this month, the Supreme Court will issue its ruling on the constitutionality of the Patient Protection and Affordable Care Act (aka ObamaCare). The justices, of course, have many options. They could strike down the law in its entirety or uphold all of it. They could strike down just parts of it, most likely the individual insurance mandate and/or the requirement that states expand their Medicaid programs, while upholding the rest. They could even decide not to decide, ruling that the law is not "ripe" for a challenge until the mandate goes into effect in 2014.

But one thing is certain, no matter how the Court decides: The battle over health care reform is far from over.

If the Court upholds the law or at least major parts of it, Republicans will still seek its repeal legislatively. And, if the Court strikes down large parts of President Obama's signature legislative accomplishment, the administration is unlikely to shrug its shoulders and forget about it.

Most importantly, regardless of the Court's decision, the problems with our health-care system are not going away.

The US health-care system has much to recommend it. We produce most of the research, innovation and technology that improves health care throughout the world. Americans have more choice of physicians and treatments than patients in other countries. And if you are sick, your chances of survival are far better in this country than elsewhere.

But one only has to open their latest insurance bill to see that the cost of health care is still going up. On average, health insurance in New York now costs nearly $6,000 for an individual and $16,000 for a family, more in New York City. Premiums are expected to rise by 8.2% this year, increasing faster than wages.

At the same time, too many Americans remain uninsured. Although the number of uninsured is often exaggerated by critics of the system, approximately 50

million Americans could be without health insurance at any given time, 2.7 million of them in New York.

Even if ObamaCare is fully implemented, as many as 23 million Americans would still lack health insurance by 2020.

What then should we do to reform health care? Here are five ideas:

1 Make health insurance personal and portable

Nothing would do more to fix our health-care system than moving away from a system dominated by employer-provided health insurance and instead making health insurance personal and portable, controlled by the individual rather than government or an employer. There is, after all, no logical reason for an individual to receive health insurance through their job. We don't receive most other types of insurance — auto, homeowners, life — in that way.

Employer-based health insurance is an anomaly that grew out of unique historical circumstances during World War II. Despite the widespread entry of women into the labor force during the war, the shift of men from private employment to the military created a labor shortage. At the same time, wage controls prevented employers from competing for available workers by raising salaries. In an effort to circumvent the regulations and compete for available workers, employers began to offer non-wage benefits, including health insurance.

In 1953, the IRS ruled that employer-provided health insurance was not part of wage compensation for tax purposes. This means that if a worker is paid $40,000, but their employer also provides an insurance policy worth $16,000, the worker pays taxes on just the $40,000 in wages. If, however, instead of providing insurance, the employer gave the worker a $16,000 raise — allowing the worker to purchase his or her own insurance — the worker would have to pay taxes on $66,000, a tax hike of as much as $2,400. This puts workers who buy their own insurance at a significant disadvantage compared to those who receive insurance through work.

Employment-based insurance distorts our health-care system in several ways. Most significantly, it hides much of the true cost of health care to consumers, thereby encouraging over consumption. If workers believe someone else is paying for their health care, they have less incentive to be frugal consumers. People naturally eat more at the all-you-can-eat buffet, than if they have to pay a la carte.

Basing insurance on employment also means that if you lose your job, you are likely to end up uninsured. Worse, once you've lost insurance, it can be hard to get new coverage, especially if you have a pre-existing condition.

Changing from employer to individual insurance requires changing the tax treatment of health insurance. Employer-provided insurance should be treated the same as other compensation for tax purposes: that is, as taxable income. To offset the increased tax, workers should receive a standard deduction, a tax credit, or expanded Health Savings Accounts (HSAs), regardless of whether they receive insurance through their job or purchase it on their own.

As a result of this shift in tax policy, employers would gradually substitute higher wages for insurance, allowing the worker to shop for the insurance policy that most closely matched his or her needs. That insurance would be more likely to be true insurance, protecting the worker against catastrophic risk, while requiring out-of-pocket payment for routine, low-dollar costs, and it would belong to the worker, not the employer, meaning that workers would be able to take it from job to job and would not lose it if they became unemployed.

And, since workers could maintain continuous coverage, the issue of preexisting conditions becomes far less of a problem.

Putting workers in charge of their own insurance would significantly reduce the cost of insurance. A study by Stephen Parente of the University of Minnesota suggests that making this change would increase the number of people with health insurance by 21-27 million, nearly as many as projected under ObamaCare.

2 Increase competition and break up insurance cartels

Putting purchasing power in the hands of consumers is only half of market-based reform. We also need to increase competition in the insurance market. Today, for example, people can't purchase health insurance across state lines. This effectively creates near monopolies in many states with only a handful of insurance companies controlling the vast majority of a state's market. For example, in New York, just two insurers, GHI and Empire Blue Cross, represent 47% of the market. In New Jersey, a single insurer, Horizon Blue Cross and Blue Shield, controls 43% of the market. And in Connecticut, Wellpoint holds an astounding 55%.

Nationwide, there are more than 1,300 insurance companies, including some 500 nonprofit, cooperative and mutual insurers. Consumers should be able to buy insurance from any of them, forcing insurers to compete on price and service.

And because different states have very different regulations and mandates, costs can vary widely depending on where you live. These regulations are a major reason why New York and New Jersey have some of the nation's highest insurance premiums. But with consumers able to escape those costly regulations by purchasing insurance elsewhere, states would be forced to evaluate whether

their regulations offered true value or simply reflected the influence of special interests.

3 Empower non-physician medical professionals

It's not just the insurance industry that needs more competition. Consumers should also have more choice of health-care provider. Nurse practitioners, physician assistants, midwives, naturopaths, chiropractors, and other non-physician medical professionals should have far greater ability to treat patients. This means rethinking medical licensure and "scope of practice" laws, which too often reflect the power of special-interest lobbies intent on preventing competition, rather than protecting public health and safety.

New York, for example, has some of the nation's tightest restrictions on non-physician medical professionals. But there is no evidence that these rules make New Yorkers safer or healthier. On the other hand, it does make health care more expensive. It is time to ease those regulations to permit more competition and choice.

4 Have seniors make their own medicare decisions

While much of the debate over health-care reform focuses on private health insurance, it is important to remember that half of all health-care spending is done by the federal government. And the 800-pound gorilla of the American health-care system is Medicare.

Medicare was essentially modeled after a 1965 Blue Cross insurance plan, and has not been substantially updated since. It pays doctors on the basis of how much treatment they provide, not on whether that treatment is effective. In fact, if the treatment makes you sicker, and you have to receive additional treatment, the doctor gets paid more. At the same time, physicians are reimbursed at such low rates per procedure that some costs are shifted onto privately insured workers, while physicians are beginning to drop out of the system.

Worse, because of changing demographics, and because most seniors receive far more in Medicare benefits than they pay in Medicare taxes and premiums, the program is threatening to bankrupt the country. Even if one accepts the most optimistic estimates for Medicare's finances, the program faces future shortfalls of more than $56 trillion. Other estimates suggest that the program's unfunded liabilities could actually reach as much as $125 trillion.

The Obama administration's answer is to empower an unelected board, the Independent Payment Advisory Board (IPAB), to further reduce physician payments. This could lead to more physicians refusing to see Medicare patients, and possibly even some hospitals closing. The president would also rely on comparative effectiveness research to weed out ineffective or overly expensive

treatments. We've seen some of this recently in recommendations for men to skip prostate screenings, or for women to delay mammograms.

A better answer would be to have the government set a fixed amount per recipient that it is willing to spend on Medicare. Then instead of directly paying hospitals and physicians, the government should turn that money over to the recipients themselves, as a voucher to help them purchase private health insurance. Lower-income seniors and those with higher health-care costs because of illness could receive a bigger subsidy.

Seniors could use these vouchers, combined with whatever they wish to spend of their own money, to choose an insurance plan that has a cost and mix of benefits that best meets their needs. Rather than the government imposing cuts from above or rationing care, seniors could decide for themselves if they wanted to pay for services over and above a minimum set of benefits.

5Let states experiment with Medicaid

The government's other big health care program is Medicaid. Like Medicare, its costs are exploding, posing serious threats to both the national and state budgets. Medicaid costs New York taxpayers more than $15.9 billion annually. At the same time, the program is notorious for providing poor care. Because reimbursements are so low, nearly a third of primary-care physicians will not accept Medicaid patients, driving recipients to hospital emergency rooms for treatment. In fact, Medicaid patients are more likely to end up in emergency rooms than are those with no insurance at all.

Congress should follow the lead of the successful Clinton-era welfare reform and return funding and responsibility for the program to state governments in the form of a block grant. This would allow states to treat Medicaid like other welfare programs, imposing work requirements, time limits, and tougher eligibility requirements. States could experiment with new delivery and reimbursement models, including subsidizing private insurance for the poor. Finally, a block grant would cap Medicaid spending and end the practice of states leveraging federal funding to expand their programs beyond what they can afford.

The Supreme Court's decision will clearly not be the last word on ObamaCare or health-care reform. As the debate goes forward, it's important to remember that there are alternatives — alternatives based on free-markets and consumer choice.

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The $8,000 mouthwash

Want another example of how healthcare costs are out of control? Check out this bill— where a 10minute trip to the emergency room ended up costing $8,252.70.

The patient hadaminor infection on his mouth and a fever. Visiting the Bayonne Hospital emergency room, his blood pressure was checked, and a nurse looked inside his mouth outside the nurses' station. He was never put in a room. She returned with a prescription for antibiotics and something called "magic" mouthwash (which contains benadryl and other ingredients). No tests were performed.

For this feat of medical excellence, Aetna was charged more than $8,000 (that's just for treatment, the prescriptions cost extra). The copay for the patient? $50.

"This is robbery and we're all paying for it," the patient said. "I can only image if I hadamore serious problem or an accident."