HEALTH CARE REFORM IN WISCONSIN
HOW WE GOT HERE, WHAT WE SHOULD AND SHOULDN'T DO

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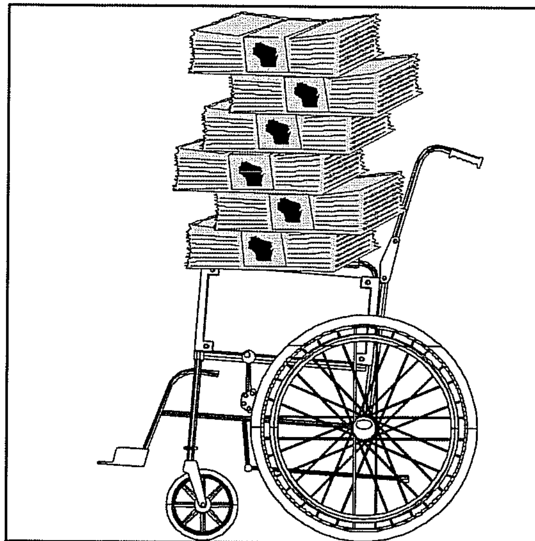
Health care reform is an issue on the minds of most Americans. Everyone agrees the rising cost of health care is creating access problems for many Americans. Divergence of opinion arises when deciding how best to solve these problems. Should government step in and completely take over the funding and delivery of health care, or should we free the current health care system from the shackles of government regulations and mandates in order to create a competitive market in an industry that, to date, has not been allowed to operate freely? If we are to be serious about comprehensive health care reform, we must do two things: 1. Understand the historical context and role government has played in the rising cost of health care, and 2. Craft solutions addressing the root problems that have created the call for reform. Above all, we must strive to protect the quality of health care we have come to know in our state. Any health care reform that jeopardizes quality will be detrimental not only to Wisconsin's citizens but to the economic viability of our state.



Good intentions and the law of unintended consequences

If there is a lesson to be learned from a century of health care regulation in the United States, it ought to be that the best intentions of lawmakers rarely, if ever, overcome the *law of unintended consequences.*

Government has played the most significant role in creating the problems that exist in our health care system. This conclusion is obvious for any objective reviewer. The regulatory history also shows that bad health care policy has been a bipartisan enterprise for generations.

From Teddy Roosevelt's first push for national health insurance to Franklin Roosevelt's wage and price controls to Richard Nixon's managed care mandate, politicians have long-touted government intervention over market forces.

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These government interventions are usually encouraged by hospitals, practitioners, insurers, employers and the voters themselves. In a larger sense, we are all to blame for the problems in the current system; however, when government acts to address the concern of one group it almost always has the effect of putting the cost onto another group.

In a report published by the Wisconsin Policy Research Institute, Linda Gorman, PhD, details how a long succession of government policies and interventions has driven-up costs and left individuals with little control over their own health care. Spanning the time since the Great Depression, lawmakers expanded the use of prepaid health plans, set the stage for the third-party-payer system and created preferential tax treatment for employer-provided health insurance. In the pursuit of expanding government-provided coverage to the poor and elderly, lawmakers have also made health care the most regulated aspect of our economy.[1]

Employer-provided health care

In 1942, Congress acted to control wages and institute price controls in an effort to control inflation and hold down the cost of wartime production. Employee wages were frozen, however employer-provided health insurance was exempted from taxes and became a non-wage fringe benefit. Employers seeking to meet their wartime production quotas began offering health insurance to attract workers.

Once in place, these benefits became part of the typical employee compensation package. This change dramatically altered the way Americans obtained health insurance and health care. In the process, insurance coverage also evolved from basic plans that covered only major medical expenses to comprehensive plans that covered routine office visits and drugs with marginal out-of-pocket costs.

Gradually, employees began to see health coverage as a *free* benefit offered by employers rather than part of their total compensation. Few employees recognize the substantial investment their employers make as forgone wages and they have become isolated from prices by having a third-party insurer pay their bills.

The isolation from cost that employers, insurance companies, and government programs have established is one of the biggest reasons for the high-cost of health care. Dr. David Gratzer sums up this health care paradox very well when he says, "American health care is so expensive because it's so cheap. That is, with Americans paying just 14 cents out-of-pocket for every health dollar, they have little incentive to economize on health expenses."[2]

Government-provided health care

Medicare

Following the path of Theodore Roosevelt and Franklin Roosevelt, Truman proposed a program for national health insurance. The idea was too pricey for FDR but, by the end of the World War II as the economy was recovering and America was nearing full employment, Truman embraced the idea. It would take 20 years before the idea would become a partial reality. In 1965, President Lyndon Johnson signed Medicare into law during a ceremony at the Truman Library in Independence, Missouri. President Truman attended and became the first person to apply for coverage under the program.[3]

Medicare, designed to work in conjunction with the thirty-year-old Social Security program, was created to provide *social insurance* to the elderly. Seniors could obtain medical care without the fear of depleting their retirement money, or relying on their children. As President Johnson said, "No longer will young families see their own incomes, and their own hopes, eaten away simply because they're carrying out their deep moral obligations to their parents and to their uncles, and their aunts."[4]

Yet, as Professor David Hyman astutely observes, "it is hard to make the case that ex-presidents are in need of any sort of subsidy from ordinary working Americans to pay for the cost of seeing a physician-but that is exactly what Medicare did (and does)."[5] For all of Medicare's good intentions of protecting

seniors and their families against the cost of care, the burden of supporting the program continues to fall on their children, grandchildren, and great-grandchildren. At the same time, the program neither rewards nor punishes providers or patients for appropriate or cost-effective utilization of health care.

At $408 billion in 2006, Medicare accounts for 3.1% of the federal budget. In 1970, the payroll taxes of 4.5 workers was sufficient to cover the needs of one retiree and provide enough extra revenue to build a surplus to meet future funding requirements. In 2006, the payroll taxes from 3.9 workers paid for a single beneficiary, but were unable to maintain the surplus funding. Without reform, the Medicare surplus will be depleted by 2019. As the ratio or workers drops to 2.4 for each beneficiary by 2030, Medicare will consume 37% of all federal revenue and require a 20% increase in income taxes to fund the program.[6]

Health outcomes have little or no relationship to Medicare's payment system.

At its inception, Medicare reimbursed providers based on the cost of care. This open-ended payment system tended to increase utilization and had an inflationary effect on health care costs. In order to control their budgets, the federal government turned to employing cost controls. Medicare now sets provider rates that underpay for some procedures while overpaying for others. The payment method itself, as one would expect, creates incentives for providers to offer the higher paying services rather than alternatives that may receive a lower reimbursement and improve health outcome. In fact, health outcomes have little or no relationship to Medicare's payment system.

The increasing cost of Medicare, combined with the first wave of baby-boomers, will present challenges to the financial solvency of the program. America's first baby-boomer began collecting benefits in January of this year (2008).[7] Predictably, Congress dealt with the increase in demand not by addressing the Medicare funding shortfall. Instead, Congress dipped into a stabilization fund to provide a *temporary* six-month 0.5% increase in physician payments. Unless Congress deals with the funding problem, by June 2008, an automatic 10% cut will be imposed on physician payments.[8]

Medicaid

In 1965 Congress also created Medicaid, a state and federal program intended to address the health care needs of the poor. Total combined federal and state spending on Medicaid was over $300 billion in 2006.[9] The program provides federal matching money to the states. Each state is given some latitude for developing their programs and the matching federal dollars vary with each state. Wisconsin's federal matching share will increase to just over 59% in 2009.

Much like employer-provided health insurance, enrollees have very little incentive to evaluate costs or consider alternative forms of treatment. Compounding this problem, Medicaid penalizes recipients for working more hours or earning higher pay. Recipients receive full coverage or a partially subsidized plan, however once a recipient hits a set income threshold they lose their coverage. Depending on their employers' coverage offerings, an enrollee faced with losing coverage because of a small increase in earnings may go from paying a few hundred dollars for coverage to thousands. Even worse, the recipient may also be required to reimburse the state for coverage from the prior year.

Medicaid in Wisconsin relies on managed

care networks to control costs. In general, these networks are effective at controlling costs, but they limit the options of beneficiaries to see individual doctors or specialists. Much like Medicare, the Medicaid managed care model is focused on containing costs with little emphasis placed on overall health outcomes.

Medicaid also provides health care and long-term nursing care to poor seniors who qualify as dual-eligible under both Medicare and Medicaid. Despite government efforts to curb abuses, many seniors have been using Medicaid as a way to shelter retirement savings and protect assets for a surviving spouse and other family members.

Under these government programs, providers receive far lower reimbursement rates for their services. As a result, many practitioners further limit the options of both Medicare and Medicaid recipients by refusing to accept enrollees or by limiting the number of enrollees they take on as patients.

The lower reimbursement rates from government programs also create the problem of cost shifting which drives up the cost of private insurance. With government spending more than 45% of every health care dollar,[10] reimbursement rates have a considerable impact on the cost of private insurance.

A recent study conducted by Stanford University Professor Daniel P. Kessler found that Medicare and Medicaid cost shifting in California's health care system is significant. Kessler concluded that hospitals could reduce the markup they charge private payers by 10.8 percentage points if the government programs paid the actual costs.[11]

The cost of state government regulation and mandates

For many years, state legislators have been passing coverage mandates for health insurance. Mandates are often adopted with good intentions; more frequently the expanded coverage is pushed by groups that stand to gain financially.

With little consideration given to the cost, legislators have mandated coverage for things like contraceptives, in vitro fertilization, acupuncture and treatment for morbid obesity. The Council for Affordable Health Insurance estimates these mandates add anywhere from 4% to 12% to the cost of a health plan.[12] Fortunately, none of these are mandated in Wisconsin—yet. Wisconsin does have other mandates, which could add as much as 6% to the cost of policies.

The issue is not whether the intention of these mandates is good or bad. The issue is, who chooses which coverage options and at what cost? If the legislature's best intentions push the cost of health insurance beyond an individual's ability to afford coverage, are the consequences worth it?

During the 1990s a few states attempted to address the cost of insurance by adjusting rate bands through a *Community Rating* system. Rate bands are used to set insurance rates for various groups of policyholders. When government gets involved in establishing or setting rate bands, it typically involves setting identical premiums for everyone in a geographic area, without regard to an individual or group's health history, age or other risk factors. Several states combined this system with a bureaucratic rate-review process that would act to limit premium increases that were thought to be unjustifiable.

A few states also passed *Guaranteed Issue* laws, which require insurers to provide coverage to every applicant regardless of health status or previous insurance status. This encourages people to remain uninsured until they find themselves in need of coverage, and thus undermining the purpose and function of health insurance.

Community Rating and Guaranteed Issue laws serve as examples of well-intentioned government interventions that have had a variety of unintended, predictable and dire consequences. Legislators in several states managed to drive out insurance providers, raise premiums substantially and force even more people to become uninsured. Despite the damage, only a few states have acted to repeal the

requirements. Massachusetts chose instead to use the crisis as the basis for expanding the government's involvement even deeper into health care under the Massachusetts Health Plan.

In a book published by The Heartland Institute, Conrad F. Meier evaluates the impact these laws had on eight states. In New Jersey, monthly premiums for a typical Blue Cross family plan went from $695 in 1994 to $5,239 in 2005. A similar policy from Aetna went from $769 to $6,025 during the same period. All of this is a result of the *death spiral* that occurs when the healthy forgo coverage as prices increase leaving the unhealthy behind to pay for coverage.[13]

Massachusetts took a slightly less aggressive approach during the 1990s; however, the regulations still drove out insurance providers and increased costs for individual non-group policies. A family policy in 2005 ranged from $14,268 to more than $27,000.[14]

Federal and state regulations are at the heart of America's health care crisis.

New Jersey lawmakers passed legislation that scaled back the rating system in 2002, however insurance still remains expensive in New Jersey and 17% are without coverage. In Massachusetts, as coverage for the poor was expanded under The Massachusetts Health Plan in 2006, 12% of the state's population remained uninsured.[15]

Federal and state regulations are at the heart of America's health care *crisis*. Government attempts at controlling costs have had the opposite effect. Our Medicare system is heading towards insolvency and threatens to take an even larger portion of worker's paychecks with little promise of providing the same level of benefits that current retirees enjoy. Medicaid continues to discourage work and it locks individuals into under-funded managed care plans that limit options for care and contribute to higher premium costs for those with private insurance.

Solutions that do not work—government-run health care

Despite the lengthy history of failed government interventions in health care, some continue to push for more government involvement, including an outright takeover of the system. Socialized medicine continues to be the preferred option for many American liberals. Despite claims made by filmmaker Michael Moore in his docudrama *Sicko*, government-run health care does not work *anywhere*, particularly in Cuba.

The Canadian health care system relies primarily on rationing to control costs. The result is a system where the median wait time between a referral from a primary care provider to the time a patient is seen by a specialist is almost five months.[16] Even with rationing, the cost increases facing the Canadian system are unsustainable. A Fraser Institute report estimates that health care costs will consume half of the nation's revenue by 2020.[17] In 2005, the Canadian Supreme Court ruled that the government-controlled system violates a Canadian's fundamental rights and that "access to a waiting list is not access to health care."[18]

While policymakers in the United States continue to push for government-run health care, almost every European nation is moving towards privatization and market-based reforms. In Britain, people may once again utilize private hospitals and obtain private insurance as some 7 million citizens had done by 2005. Australia and Germany have also moved towards private insurance.[19]

Healthy Wisconsin

Ignoring these trends, Wisconsin's Senate Democrats chose to introduce "Healthy Wisconsin," a government-run health care plan. Healthy Wisconsin was unanimously adopted as an amendment to the Senate Democrat's version of the state budget. The plan was never brought to a vote in the Assembly because not one Democrat was willing to bring the plan to the floor. Legislative Democrats will be pushing another version of the plan during the spring session.

Supporters insist their plan is not government-controlled because the health care providers remain private. While this characteristic may distinguish Healthy Wisconsin from the Canadian system, the plan places significant decision-making powers and financial controls into the hands of state government, which inarguably represents a government-controlled takeover of the health care system in Wisconsin.

One of the lead authors, Sen. Jon Erpenbach, maintains the plan is not government-run, but is actually a "balanced public/private partnership in which the government plays a limited role . . .[i]t is a market-driven plan"[20] Unfortunately, such temerity is not sufficient to overcome the actual language found in the legislation.[21]

Healthy Wisconsin represents a top-down, government-controlled takeover of the funding and financing of health care. The legislation establishes the Healthy Wisconsin Authority that would consist of a 16-member board appointed by the governor. The board has the authority to set the payroll tax-rate up to 16%, define and modify plan benefits, set co-payments and deductibles, certify health care networks, accept bids, establish provider payment methods, audit health care networks for compliance, and regulate various aspects of the service providers, including "appropriate" investments in technology and equipment.[22] The board would also have the authority to determine standards of medically appropriate care and best practices, yet, not a single voting member of the board is a health care practitioner.[23]

The Department of Revenue would be responsible for collecting the taxes,[24] and the Department of Administration would be required to design "*cost containment*" measures.[25] The legislation even defines the Healthy Wisconsin Authority as a state agency.[26] This is hardly a partnership with a limited government role. The plan puts the power to tax and make the rules into the hands of government.

An individual choosing to opt out of the plan would be assigned to a health care network and would be required to pay the tax, either through a payroll deduction or through a 10% surtax on their passive income. Individual doctors or clinics that do not wish to participate in a *coordinated network* will not be covered under the plan.

Under Healthy Wisconsin, the Authority would supplant private insurance. The use of insurance would be limited to supplemental coverage. Individuals would be offered two types of plans; a managed-care plan provided by the lowest bidding network in an individuals market, or a fee-for-service plan that would cost as much as $2400 more. This, the supporters insist, is the cost containment mechanism in their health plan. The competition between these two plans and between competing networks of hospitals and practitioners would supposedly force them to "compete aggressively."[27]

The managed care and fee-for-service offering is based on Professor Alain Enthoven's managed competition model.[28] In Enthoven's testimony before the Wisconsin State Senate, he praised the plan as being "exactly what this state needs to get its health care system on the track of quality and economy. Like every market . . . this market needs rules and management. But with that, who can be opposed to a big dose of free market forces."[29] Yet, Professor Enthoven admits that the model is not a free market model.[30]

Mike Tanner of the Cato Institute, in his testimony before the Assembly Committee on Health and Health Care Reform, noted that the managed competition model was the "concept

behind both the 1993 Clinton health care plan and Mitt Romney's Massachusetts reform; it is designed to take advantage of market competition, but within an artificial and carefully regulated marketplace." Tanner also noted that Healthy Wisconsin "combin[es] managed competition with key features of a single-payer plan such as global budgeting, thereby borrowing the worst of both worlds."[31]

The proponents of Healthy Wisconsin claim the plan will contain costs, but Enthoven indicated in an interview with the *Milwaukee Journal Sentinel* that supporters are "naïve" because under a plan like Healthy Wisconsin, "politicians will decide what doctors and hospitals get paid, and special interests will lobby for higher payments. 'The government often gets it wrong in setting prices,' Enthoven said."[32]

The state of Wisconsin cannot even manage to implement a Medicaid software system on time or on budget.

The proponents argue that having the state replace insurance companies eliminates their overhead. This presumes the state can manage the entire health care system for less money, which almost certainly is not possible. The state of Wisconsin cannot even manage to implement a Medicaid software system on time or on budget.[33]

According to the Lewin Group report provided to AARP, Healthy Wisconsin will reduce what it spends on coverage for non-elderly residents from $18.2 billion a year to $17.7 billion. The numbers include $15.2 billion from the new payroll tax, and a variety of other savings including $407 million from reductions in administrative costs, $560 million dollars in savings from "primary care emphasis"—which means reducing the number of referrals to medical specialists, and another reduction of $178 million from the centralized purchasing of prescription drugs.[34] The plan would also move 166,000 individuals who currently have insurance onto Medicaid.[35]

Even if the financial projections were borne out, the question would remain; will this slow medical inflation? The answer is no. Healthy Wisconsin, in theory, could reduce the costs one-time by completely restructuring the management of health care in the state, but it does not reduce the year-after-year cost increases in any significant way. The Lewin Group presentation illustrates this by showing a nearly parallel ten-year trend line between continuing with our private insurance (costing $35 billion by 2017) as opposed to adopting Healthy Wisconsin (costing $33.1 billion by 2017).[36]

Healthy Wisconsin reforms almost none of the flaws in the current system. Much like Medicare, the plan calls for a global payment system. While the legislation spells out the need for maintaining quality, the payment system is not designed to reward innovation and quality. Patients have no incentive to moderate their health care consumption because the plan uses very small deductibles and co-pays, leaving in place the elements that have made individual health care consumers insensitive to cost. In the same way that Medicaid punishes work, Healthy Wisconsin places a larger burden on those with higher incomes. A working person and an unemployed person would have the identical coverage, yet one is paying far more than they would under private insurance, while the other pays nothing. As people begin to see the plan as an entitlement—with no rewards for proper utilization—the cost of the program will skyrocket.

The only way Healthy Wisconsin addresses rising costs is by utilizing containment strategies, just as Medicare, Medicaid and socialized programs in countries like Canada.

Rationing and reducing reimbursements are government's brute force methods of controlling costs. Cutting reimbursements drives out higher-quality practitioners and forces hospitals to compromise on innovative technologies. Rationing reduces access and affects health outcomes.

This would be the constant battle played out in the state capitol. Providers will demand higher payments, patients will demand reforms that provide them with more services for less money, and everyone will want to control taxes. Government is ill-suited to balance these demands.

Beyond the negative impact the tax would have on Wisconsin's economy and the attack on personal liberty the plan represents, Healthy Wisconsin poses a substantial threat to the quality of health care in Wisconsin.

Fortunately, people in Wisconsin appear to understand the inherent problems of Healthy Wisconsin. In a poll conducted by Wisconsin Manufacturers and Commerce, respondents who had heard details of the plan overwhelmingly opposed the idea with 62% indicating their disapproval.

The proponents of Healthy Wisconsin believe their plan is a "magic-bullet," a one-size-fits-all panacea for health care. That way of thinking is precisely how we got to this point in American health care.

Government cannot possibly manage a system as complex as health care. Much like any other government solution, the best approach is usually found at the most local level possible. In health care, the most local level is between the patient and the doctor. Many reform proposals and the current system tend to focus on reforming the system of care, rather than the incident or episode of care.

Solutions that work—building a free market where one does not exist.

Proponents of government-run health care often claim that free-markets have created the problems facing health care and that consumer-driven health care will not work or that it is an unproven idea. For the most part, there is no such thing as a free-market in health care today. At the same time, we know free-markets work. The evidence is all around us. Every other purchase and investment we make occurs in a free-market. The solutions for health care will be found when we pursue consumerism and market forces as the tools of reform.

Valuable lessons can be learned from the field of dentistry where consumers exist in large part because they spend their own money, or are covered by insurance with higher out-of-pocket costs. The price for most procedures has remained stable because people regularly check with different providers regarding price and they inquire about alternative treatments. Conversely, dentistry also provides an example of what happens when government is involved in providing people with coverage. The Medicaid reimbursement rate for dental care is among the lowest of any health practice. As a result, few dentists take Medicaid patients and those that do restrict the number they will see.

The overarching goal of free market health reforms is to create an army of consumers with information and tools with which to make decisions about their health care. This can be achieved through policy changes that promote individual ownership of health insurance, allow individuals and groups a greater array of choices when purchasing insurance, promote the disclosure of pricing information and create incentives for the uninsured to participate in the private insurance market.

Promoting ownership and choices

One of the biggest reforms needs to take place at the federal level. We need to change the tax code to eliminate the preferential tax treatment given to employer-provided health insurance. At the state level, in Wisconsin, the issue received bi-partisan support. Governor Doyle signed this provision into law as part of our current state budget. Congress must do the same.

Peter Nelson with the Center of the American Experiment issued a report detailing the distortions that employer-based coverage

has on the health insurance markets. His analysis found:

- Employment-based coverage restricts consumer choice.
- Lack of choice limits competition in the health insurance marketplace.
- Lack of choice undermines health insurers' ability to evaluate consumer preferences.
- Employment-based insurance restrains the development of benefit designs and contracts focused on long-term health.
- Employers do not closely monitor the cost and quality of health plans.
- Employees fail to monitor the cost and quality of care.
- Benefits are frequently more generous and the costs are higher in employment-based health plans.
- Less cost-sharing in employment-based plans leads people to overuse medical services, which can be costly.
- Generous health plans force many workers to take a higher proportion of their total compensation in health benefits than they would like.
- Generous health plans lead some lower-income workers to turn down coverage and remain uninsured.

Nelson also refers to The Mayo Clinic Health Policy Center's recently released health care reform recommendations. At the top of the list of 19 policy recommendations was "mov[ing] from employer-based insurance to portable, individual-based coverage."[37]

Consumerism occurs when we allow individuals to choose health plans that meet their needs, rather than having employers or government make choices on their behalf. With or without changes in the tax laws, employers must put pressure on insurers to diversify their health plans in ways that allow individual employees to choose coverage options that meet their needs. Group health insurance can and should be designed to address individual needs.

Moving away from employer-based insurance, or at the very least restructuring the relationship between the employee and the insurer, would be a significant step towards reform. Employers and individuals must demand that insurers provide value beyond merely negotiating with providers and paying bills on our behalf. The additional administrative costs incurred by insurers would be more than offset by the cost savings generated by working more closely with individual enrollees.

Consumerism occurs when we allow individuals to choose health plans that meet their needs, rather than having employers or government, make choices on their behalf.

With the exception of *wellness programs*, individualized incentives and tailored insurance plans are foreign to today's health insurance industry, primarily because they focus on marketing their products to employers rather than individual consumers. Imagine if an insurer sent an enrollee a cash reward or offered a premium reduction for using health care wisely. Perhaps an enrollee who identified a medical billing error could be sent a check for a percentage of the savings. These types of incentive programs are common with homeowner and automobile policies.

Wisconsin should also allow those seeking to purchase individual policies the option of choosing the type of coverage they want. An insurer could provide a menu of coverage mandates along with the cost. Individuals could then choose the desired benefits for themselves rather than having the state make these decisions for them.

Another way to accomplish this and to increase competition among insurance providers is to open Wisconsin's insurance markets to out-of-state providers. Almost all large employers self-insure and are exempt from state regulations and coverage mandates. This leaves small employers and individuals as the only targeted group picking up the tab for legislative good intentions. Individuals and businesses should be able to select from a wider range of insurers with less government interference. Robust competition in the insurance market would help stimulate innovative plans and would make premiums more competitive.

Advocates of consumer-driven health care also support the adoption of High Deductible Health Plans coupled with tax-free[38] Health Savings Accounts (HSA). These Consumer Driven Health Plans provide a tangible and meaningful way for individuals to hold down costs. They also help return health insurance to its original purpose—protecting individuals against major medical costs.

Consumer Driven Health Plans are designed to move away from the notion of prepaid care covered under an insurance policy and towards building health savings. While a traditional health plan may cost $12,000; a popular High Deductible plan would cost $6995, a net savings of $4005, which could be put into an HSA and would cover most of the plan's maximum deductible of $4541.[39] Under a traditional insurance plan, a family that has very little health care use gets nothing back. With a consumer-driven plan, the unused balance remains in the HSA. In the long-term, HSAs should be allowed to build up a balance during the years when most people have fewer medical expenses so that they can cover future expenses.

Regardless of the incentive that a health insurance plan offers, whether it is found in an HSA, or in traditional first-dollar coverage plans that offer discounted premiums, consumers of health care must obtain some sort of financial benefit from choosing the most effective care at the right price. This is the only way to control the costs of health care. The law of unintended consequences, particularly in a complex system like health care, is too pervasive to justify additional government attempts to artificially regulate costs.

Health care transparency

A significant part of consumer-driven health care is transparency, the rather simple notion that someone who wishes to obtain a service should have at least some idea of the cost and the relative quality of the service offered by a provider. Without an awareness of costs, consumers would be unable to evaluate their options and the savings or additional cost associated with their choices.

In health care, transparency is a radical idea. Mentioning the word around providers, hospitals, and insurers induces fear and concern. To consumers—who demand this type of information in all other aspects of their lives—this type of disclosure is expected. Wisconsin is a pioneer in price transparency. Today, the Wisconsin Hospital Association provides pricing data on services provided by hospitals at its PricePoint website.[40] More can be done. Insurers are also beginning to offer price and quality data. Health care consumers need to know the total cost of an episode of care and their actual out-of-pocket costs. Insurers, particularly those who put a priority on adding value to their services, are in a better position to offer that information to their customers than providers are.

Individual practitioners are often just as isolated from cost as the patients. Transparency will help individual providers identify alternatives to expensive tests or treatments as patients become informed health care consumers.

Transparency will also put pressure on hospitals to address their overhead costs. Hospital costs have increased dramatically over the years, fueled partly by technological advancements, however observers also point to significant levels of waste and inefficiency. Quantifying these inefficiencies is difficult and much of the waste comes from the bureaucratic requirements of insurers and government.

Unlike virtually every other industry, health care—particularly hospitals, have had little incentive to adopt practices aimed at eliminating operational inefficiencies from their systems. Employers have been pressuring health insurers to control costs for years with little success, until recently. In the *Milwaukee Journal Sentinel*, Guy Boulton reported "[c]ost-cutting measures by hospitals in the Milwaukee area are beginning to pay off."[41] Hospitals are beginning to implement "techniques long used in manufacturing." These techniques have evolved since the 1980s and were driven by foreign competition. American industries had to relearn everything they thought they knew about quality and efficiency in order to compete. The automobile industry worked out these problems twenty-years ago by developing standards for interoperability of electronic data. Health care in America is just beginning to adopt a set of standards that allow for the exchange of medical records and medical billing data.

Hospitals will also need to restructure the way they provide care. As consumers consider cost and health outcomes more carefully, hospitals must focus on better ways to manage chronic illnesses – a major cost-driver in health care. Caring for patients with chronic diseases will change if insurers and consumers put pressure on providers to adopt more tightly integrated approaches to care. Marshfield Clinic has been doing this under a Medicare demonstration project with great success.[42] Harvard Professor Regina Herzlinger proposes integrated care teams focused around treating patients with chronic disease. Her approach, much like Marshfield, uses a team of coordinated specialists working together to control the illness and treat the various symptoms. She calls this approach a *"Focused Factory"*[43] These innovative approaches can improve outcomes and lower costs.

If we want to look at reforms that would make a difference, then we need to examine the flaws of BadgerCare.

Without consumers possessing a financial incentive to shop for services, health care providers do not need to compete for their services, nor do they have any significant pressure to reduce waste and inefficiency. Transparency that allows individuals to evaluate quality and price will provide that pressure.

Incentives for the uninsured

While consumer-driven health care offers the promise of controlling costs, the question of providing coverage to the uninsured remains. The supporters of government-run health care believe their approach is the only way to accomplish this. Overhauling the entire health care system is not the answer.

In order to address the problem of the uninsured, we have to identify who they are. In Wisconsin, the percentage of uninsured is at about 8% and about half were insured for part of the year.[44] Unlike many other states, Wisconsin ranks among the lowest in uninsured. Most of the uninsured are in households below 200% of the federal poverty level and therefore eligible for BadgerCare or premium assistance.

If we want to look at reforms that would make a difference, then we need to examine the flaws of BadgerCare. Because of federal regulations, participants are often pushed out of the program due to changes in employment status or an increase in earnings—even if the increase is short-term. BadgerCare should not crowd-out private insurance offered by employers, nor should it discourage work.

Many of the uninsured lack access to employer-provided health insurance. Another group of uninsured is the *"young invincibles."* They are typically 25 to 34 years old and in good

health.[45] Many choose to take higher wages rather than benefits from their employers. These workers would benefit if individual insurance had the same tax-treatment as employer-provided coverage. Allowing these individuals to choose from less expensive policies with fewer mandates would also have an impact.

One solution that may help many employees is the creation of a Health Premium Account. Using an existing federal tax exemption, workers could direct their employers to deduct pre-tax dollars from their wages and deposit them into an account set up to pay their payments. The availability of this type of account would be particularly attractive to part-time and seasonal workers with multiple employers. These individuals are typically not offered insurance because of the limited hours they work at each job, yet many are working more than 40 hours a week. Employers who are competing for these part-time workers could voluntarily contribute to the account as a way to attract new workers. Employees can contribute to the account as well. This could be a powerful incentive to ownership of insurance and will allow individuals to carry policies regardless of employment or health status. To reduce the burden on small businesses, the deposit process would work in the same manner as child-support payments. Insurers would draw the premium payments from the account at determined intervals.

Health Premium Accounts could also be used in conjunction with the state's premium assistance program. Individuals who are eligible for BadgerCare, but wish to obtain private insurance, could use the Health Premium Account to receive the state subsidy and combine it with their own wages or an employee contribution.

Health consumers will control costs

Consumer-driven health care is a significant paradigm shift and it is a change that can make a significant difference in controlling the cost of care. Rather than allowing bureaucrats to take over our entire health care system, we need to put it back into the hands of the patient and their doctor.

Most of the reforms needed for this new direction already exist. Government's primary role in consumer-driven health care is to identify the obstacles it has placed in the way of the market and remove them. Elected officials must always be careful to avoid the law of unintended consequences and they must resist the temptation to create mandates and harmful regulations. To be effective, any reform proposal must address cost, quality, and access and each must be given their proportionate consideration in every proposal. Ideally, the best reform allows the individual to set those proportions according to their own needs.

Above all else, we must protect the quality of our health care system. In 2007, the Agency for Healthcare Research and Quality issued their National Health Care Quality Report ranking Wisconsin number one for quality.[46] We cannot jeopardize that quality and we should not turn the management of that system over to government.

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