Center for American Progress Action Fund

Conservative Health Reform

Why It Could Deepen Our Health System Crisis

Jeanne M. Lambrew, PhD
March 2008

www.americanprogressaction.org

CONSERVATIVE HEALTH REFORM

Why It Could Deepen Our Health System Crisis

Jeanne M. Lambrew, PhD
Center for American Progress Action Fund

March 2008

Contents

Executive Summary

The health system crisis in the United States is a top issue in the 2008 presidential and congressional elections. Most conservatives' solution to this crisis is "consumer-directed health care." This market-oriented model gives individuals increased responsibility for their own health care spending by encouraging high-deductible health insurance purchased in the market offering individual policies. To advance this model, they would scale back the role of employers and government in guaranteeing high-quality, efficient, and accessible group coverage. A review of the research suggests that this approach could deepen our nation's health system crisis in several key ways.

High deductibles could lower access. The conservative plan would replace upfront insurance with health savings accounts and high-deductible plans. This could:

- **Discourage the use of needed care.** Enrollees in consumer-directed health plans were 50 percent more likely to report a cost-related access problem compared to those in traditional plans. More than half of such enrollees report that the high deductible applies to prevention. People with chronic illnesses such as asthma, arthritis, and high cholesterol were two to three times as likely to fail to fill a prescription due to cost when enrolled in such plans compared to traditional insurance.

- **Depress the quality of care.** Few people in consumer-driven health plans reported access to information on the quality of their providers. The proportion of enrollees reporting that they were very or extremely satisfied with their health plans was 37 percent in consumer-driven plans compared to 67 percent in traditional group plans.

A shift from group insurance to individual insurance market could diminish coverage. The conservative plan to replace employer and public insurance with fully-insured, individual-market health plans presents a number of problems. It could:

- **Undermine what limited protections exist in the individual market.** Conservatives would promote individual-market insurance, in part, through deregulation. Already, coverage in this market provides little protection: Enrollees with low income and high costs spend roughly 50 percent of their income on health costs, or about the same as the uninsured. Only five states prevent insurers from denying policies to individuals based on their health status. Over 70 percent of individuals in poor health found it very difficult or impossible to find affordable, individual-market coverage.

- **Put millions of already-insured people at risk of losing coverage.** By ending employers' tax incentive to fund health benefits, many of the 160 million with employer coverage today could lose it. If they lose it, then they may not be able to regain it in the individual market. Conservative plans allow insurers to deny access to coverage for those who have pre-existing conditions, who are older, or who have some other risk factor. The president's plan, which would replace the current tax break with a tax deduction for health insurance, could result in 12 million people with employer-based coverage losing it. This loss would likely be greater under plans with tax credits that make it easier for low-wage firms to drop coverage.

- **Worsen the uninsured problem.** Health savings accounts, a mainstay of conservatives' plans, provide greater tax breaks to high-income participants. Yet 55 percent of the uninsured do not pay taxes due to low income. If not paired with market reforms, even refundable tax credits could increase the number of uninsured. According to one analysis, President Bush's original tax credit idea could have increased the ranks of uninsured by 600,000 as those with employer coverage lost it and could not regain it in the individual market. Even if conservative tax credits result in a net gain in coverage, the composition of the uninsured population would change, becoming sicker and harder to insure.

Lead to higher health system costs. Conservatives, trusting the marketplace to solve the cost crisis, would disband group purchasing and deregulate insurance. This would:

- **Do little to affect excessive use and prices.** The average U.S. out-of-pocket spending per capita on health care is already twice as high as in comparable nations. People paying for health care out of pocket are typically charged higher, not lower, prices than people getting group rates—especially given the lack of price transparency. And individual-market insurers tend to compete by seeking low-cost enrollees rather than lowering the price and use of care.

- **Raise administrative costs.** Currently, Americans pay nearly six times as much per capita on administrative health costs as residents of peer nations. This would likely increase with a shift to the individual market, whose administrative costs range from 25 percent to 40 percent compared to 10 percent for group coverage. Shifting funds from self-insured to fully-insured plans would increase insurers' power and probably profits. Moreover, new administrative costs would be generated in the banking industry that manages accounts: One analysis estimated that the cost of financial fees could be over $5 billion over the next five years.

- **Diminish the effectiveness of cost savings initiatives.** Leaving tens of millions of Americans uninsured perpetuates cost shifting, contributing to higher premiums for the insured. One analysis estimated that each family pays an extra $922 in premiums to fund uncompensated care. This creates a vicious cycle that results in more uninsured Americans. It also limits the potential of policies that could lower the cost trajectory, such as widespread use of effective prevention and management of chronic disease.

In short, conservative health system proposals are both radical and dangerous, including those offered by Senator John McCain (R-AZ) and Senator Tom Coburn (R-OK). Eliminating the current tax subsidy for health insurance and replacing it with a new one would dramatically change the way that nearly 160 million Americans get coverage. Workers could lose employer-based coverage without gaining an affordable, accessible alternative source of coverage. The impact would be even larger if public programs are scaled back and all Americans are expected to join high-deductible health plans. High-deductible plans in a de-regulated individual insurance market would shift costs to the poor and sick. And, its flawed theory and design together could actually raise health system costs, exacerbating the health system crisis.

Unsustainable Health System Trends

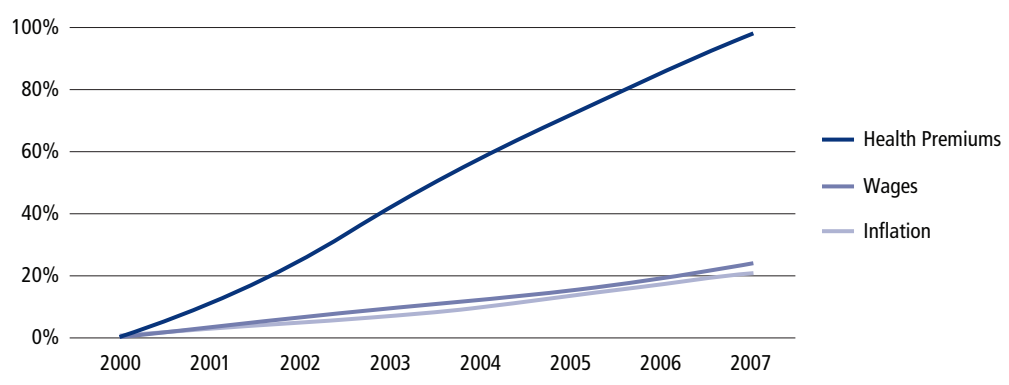
Concerns about the U.S. health system have surfaced as a top issue in the 2008 presidential and congressional elections.[1] This increased anxiety reflects an acceleration of the shortcomings and failures in how we organize, deliver, and pay for health care. Health care costs are climbing, access is eroding, and quality is erratic. This has led policymakers across the political spectrum to craft solutions.

This paper examines conservative health policy proposals. After reviewing the health system's current problems, it describes conservatives' theory and specific policy proposals. It then reviews the research about these policies' actual and potential impact. This paper neither rebuts the theory nor examines the ethical implications of "consumer-driven health care." Instead, it offers evidence about whether conservatives' plans could improve access, quality, and efficiency of our health system.

Unrelenting Health Cost Increases

The United States spent $2.1 trillion on health care in 2006, the last year for which complete data are available, or about 16 percent of our entire economy. This is twice as much as was spent in 1996. It is projected to double again in the next decade.[2] Americans spend the most in the world on health care by any measure. The size and growth in costs poses risks to our economy since it siphons off resources that may be put to better use. Although public financing of the U.S. health system is lower than that in all

HEALTH PREMIUMS RISING
Cumulative Growth in Health Premiums, Wages, and Inflation, 2000–2007



Source: Kaiser/HRET Health Benefits Survey 2007.

but one other industrialized nation,[3] its growth is faster than revenues. As the Director of the Congressional Budget Office recently noted, "No other single factor will exert as much influence over the federal government's long-term fiscal balance as the future growth rate of costs in the health care sector."[4]

Health costs strain American businesses, which finance about one-fourth of the health system spending.[5] Employer-sponsored health insurance premiums rose by 98 percent between 2000 and 2007—four times faster than cumulative wage increases (see chart, page 4).[6] During the same period, the percent of employers offering health benefits to workers fell from 69 to 60 percent.[7] This year, health benefit costs may eclipse profits in Fortune 500 companies.[8] Health costs are increasingly limiting businesses' competitiveness nationally and globally. One economist estimates that between 28 million to 42 million jobs are susceptible to outsourcing, in part due to U.S. health costs.[9]

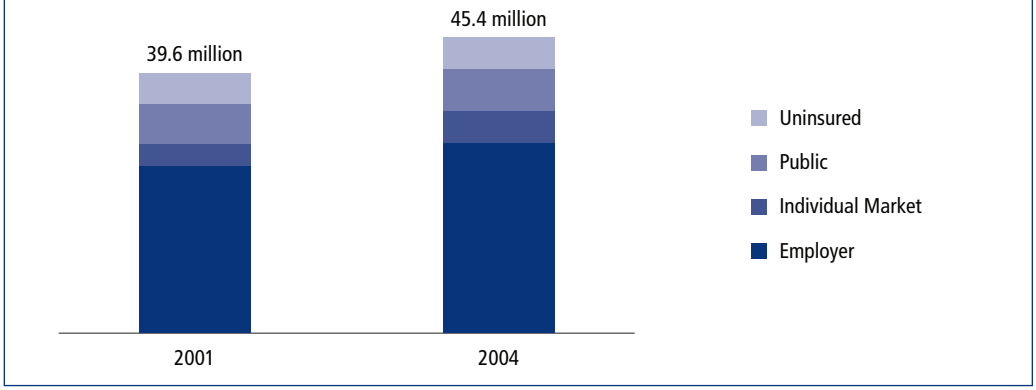
Average Americans may be suffering the most. Maintaining health insurance has meant forgoing wage increases—income that is needed by many, especially now, as the economy worsens. The average cost of a family, employer-based insurance policy in 2007 was $12,106, nearly the full-year, full-time earnings of a minimum wage job.[10] In addition to high premiums, people are paying higher amounts for deductibles and service use. Between 2001 through 2004 alone, the number of non-elderly Americans spending more than 10 percent of their income on health costs jumped by 6 million or about 15 percent (see chart below).[11]

Health costs continue to be major source of personal bankruptcy, too, accounting for 50 percent of all bankruptcies according to one study.[12] The issue also affects seniors: rapidly rising premiums and cost sharing erode retirement savings. One analysis predicts that the typical elderly couple would have to save nearly $300,000 to pay for health costs not covered by Medicare alone.[13]

Eroding Access to Coverage and Care

The high and rising costs of health care and coverage impede access to it. In 2006, 47 million Americans, nearly

NON-ELDERLY WITH HIGH OUT-OF-POCKET BURDENS



Source: Banthin et al., *Health Affairs*, January/February 2008. High out-of-pocket burden defined as spending more than 10% of after-tax family income on premiums and out-of-pocket health spending.

16 percent of the population, were uninsured, up roughly 8 million since 2000.[14] This includes nearly 9 million children who lacked coverage at some point in time in 2006. Looking over a two-year period, the number swells: fully 82 million Americans had at least a temporary gap in coverage in either 2004 or 2005 (see chart below).[15] If trends continue, another 7 million will be added to the ranks of the uninsured by 2012.[16]

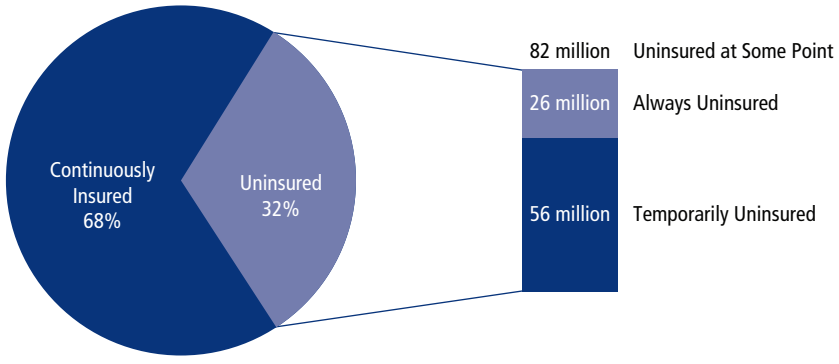
While most uninsured have low incomes, more middle-income working Americans are falling into the same trap. Nearly half of the increase in the uninsured population between 2005 and 2006 occurred among middle-income families.[17] About 18 million of the 47 million uninsured have a household income that exceeds $50,000.[18] These trends can be explained by the erosion of employer-based coverage. The number of non-elderly Americans covered by employer-based health insurance fell from 66 percent to 61 percent between 2000 and 2006.[19] With few affordable alternatives, people losing employer coverage often become uninsured. Almost 80 percent of the uninsured in 2006 lived in working families.[20]

Lacking health insurance too often means less use of needed care and greater risk of illness or death. About 25 percent of uninsured adults report delaying or forgoing needed health care due to cost—a percentage that is five times higher than among insured people.[21] A recent study found that uninsured people who were injured or developed a chronic illness were less likely to receive initial and follow-up care, impeding recovery and accelerating the worsening of the condition.[22] One review found that the risk of death is typically 25 percent higher for uninsured versus insured patients. Roughly 22,000 people die each year due to lack of coverage.[23] This is higher than number of people who died of homicide in 2006 (17,034).[24]

Sporadic Quality of Care

The United States leads the world in innovation and has some of best health care providers. But we lack systems to promote high quality care across providers and patients. A landmark study found that recommended care is provided only 52 percent of the time.[25] Medical errors

HEALTH CARE COVERAGE
Nearly One-Third of Non-Elderly Have Gap in Coverage, 2002–2005



Source: Rhoades and Cohen. August 2007. The Long-Term Uninsured in America, 2002–2005. U.S. DHHS, AHRQ, Statistical Brief #183.

are higher here than in comparable nations.[26] We lag behind other nations in the use of error-reducing techniques such as health information technology.[27] And the Institute of Medicine estimated that tens of thousands of deaths result from low-quality care.[28]

Interaction between Cost, Access, and Quality

The problems in the quality, accessibility, and cost of health care and coverage are interconnected. A recent study found that, among 19 industrialized countries, the United States had the highest rate of deaths due to diseases amenable to health care.[29] This can partly be attributed to the access problems of our large uninsured population which, in turn, is an outgrowth of our high costs. It also stems from weak systems to promote continuous, appropriate, and affordable care among the insured population. A typical physician sees patients with dramatically different types of insurance, co-payments, limits on coverage, and quality requirements—all of which complicate the receipt as well as delivery of high-quality care.

The connectedness of health system problems is also visible in our emergency system. While designed to treat sudden, urgent health needs, emergency rooms have become a safety net for uninsured and underinsured Americans. As this population has grown, so too has the strain on this system. Between 1994 and 2004, emergency department visits rose by 26 percent while the number of emergency departments dropped by 9 percent.[30] As a result, between 1997 and 2004, the average wait for care in emergency departments for people with heart attacks increased by 11 percent—even though minutes can mean the difference between life and death.[31]

Quality as well as access suffers. And the cost is high. Emergency departments, staffed by highly trained professionals, are an expensive way to deliver primary care to an underserved population. The uninsured generally cannot pay for these costs, most of which get passed along to the public, adding to a vicious cycle of rising costs. This illustrates why reform should aim to simultaneously improve access, quality, and efficiency.

The Conservative Solution to Health Reform: The "Ownership Society"

The public pressure to address the health system shortcomings comes from Americans across the political spectrum. In a December 2007 survey of top issues, health care took second only to the war in Iraq among Republican as well as Democratic respondents.[32] And this pressure is not new. It forced conservatives in 1993 to develop an alternative to the progressive proposals of the Clinton Administration and the then-Democratic Congress. Vestiges of this conservative plan were a plank in the Contract with America that helped elect a Republican majority in Congress in 1994. And many of the policies went from theory to practice during the Bush Administration, with backing from a Republican Congress between 2002 and 2006.

Theory of Consumer-Driven Health Care

Conservatives' paradigm for social policy has been dubbed by President Bush as the "ownership society." It aims to scale back public, community, and employer involvement in social programs and to give individuals a greater stake in promoting their own welfare.[33] It predates President Bush, emerging several decades ago as a "rejection of socialism" in favor of private, free-market solutions.[34] Proponents believe in self-motivation over bureaucracy, and that government programs deny choice and deaden personal responsibility. In policy terms, this has taken the form of school vouchers that replace public school support; private accounts that replace Social Security; and outsourced workers that replace government employees.

In health care, the manifestation of the ownership society is called "consumer-directed health care." Similar to ownership-society application elsewhere, consumer-directed health care would cap and turn over public (and employer) funding for health benefits to individuals. These individuals would assume the risk and responsibility for purchasing health care and coverage in a competitive marketplace. And, if the theory works, health providers and insurers, competing for patients and enrollees, would lower price and raise quality.

As a Heritage Foundation scholar recently explained: "The conservative alternative to 'socialized medicine' is to enact serious reforms in the current tax and insurance law that would expand personal ownership and control of health insurance and transfer the control of health care dollars to individuals and families."[35]

The most prominent of the policy actions to achieve this vision are health savings accounts. First proposed as medical savings accounts in the early 1990s,[36] HSA accounts are designed to allow owners to pay for health care costs directly rather than through insurance. They are often seeded with employer contributions or government funding either directly or through tax subsidies. The accounts are linked to a high-deductible, catastrophic health insurance plan that covers costs above some threshold (usually around $5,000 for a family).

By replacing up-front insurance coverage with direct spending from accounts, proponents expect that consumers will focus on price and quality, use only what health care is needed, and purchase the benefits that suit their needs. By having control over their accounts, consumers will "reap the full benefits and bear the full costs of decisions they make."[37]

Equally important to achieving the conservative vision is vesting individuals with decisions about insurance. In public health insurance programs such as Medicare and Medicaid, this means replacing the traditional, defined-benefit programs that directly pay health care providers with defined contributions to fund private health care plans, often with high deductibles, that determine payment and coverage. The rationale is that government programs are overly generous, with too little "skin in the game" for enrollees, ill-suited to meet diverse needs, and hostile to innovation. Conservatives seek to turn over public funding to individuals in lump-sum amounts to purchase private insurance. Ideally, conservatives would like this program to take the form of capped tax vouchers for health savings accounts with high-deductible plans.

A shift from employer to individual control over health benefits is a plank in the conservative plan as well. A central theme of the ownership society is portability: People frequently change jobs and life circumstances and should not be tied to a job for health or other benefits.

Currently, 61 percent of non-elderly Americans receive health coverage in the employer-based health system.[38] This system developed in the early part of the 20th century and has been kept in place in part because of the tax advantage it offers. Specifically, individuals can exclude employer contributions to health benefits from income when it comes to paying taxes. The value of this tax break exceeds $200 billion a year.

Conservatives have long advocated providing the same tax break to individual market insurance and divorcing tax breaks from employer coverage. Both policies would accelerate the decline in health coverage through employers. This would build the individual market that conservatives would deregulate directly or by "cross-state shopping," meaning an individual could purchase insurance in any state, including the one with the least regulation.

In summary, conservatives' unswerving belief in markets manifests itself in health savings accounts and individual-market, high-deductible health insurance policies. Breaking apart the pooled purchasing power of government and employers while exposing individuals directly to health costs would result in greater demand-side power, they argue. If people "own" their health care dollars, then they will use care more judiciously.

This approach also enables "personalized" medicine. Conservatives argue that

health care suppliers—insurers, hospitals, doctors, and drug companies—would be forced to truly compete for customers, lowering price and raising quality. Proponents expect this dynamic will yield more insured people, lower health system costs, and better quality of care.

This theory has been challenged since its inception but with its partial enactment over the past seven years, its practice can be assessed as well. President Bush, through executive actions and legislation, has overseen implementation of elements of conservative health reform.

Implementation of Health Savings Accounts

High-deductible health plans linked with savings accounts have been advanced in private as well as public insurance during the Bush administration. In June 2002, the Internal Revenue Service issued a ruling allowing funds in Health Reimbursement Arrangements to roll over each year and grow tax free. In late 2003, as part of the Medicare drug benefit, even greater tax incentives were created for HSAs. Individuals with HSAs do not pay taxes on account deposits, the earnings, and withdrawals if used for health care. Unused balances remain available forever and keep generating investment income until used. No other form of savings gets this level of tax break.

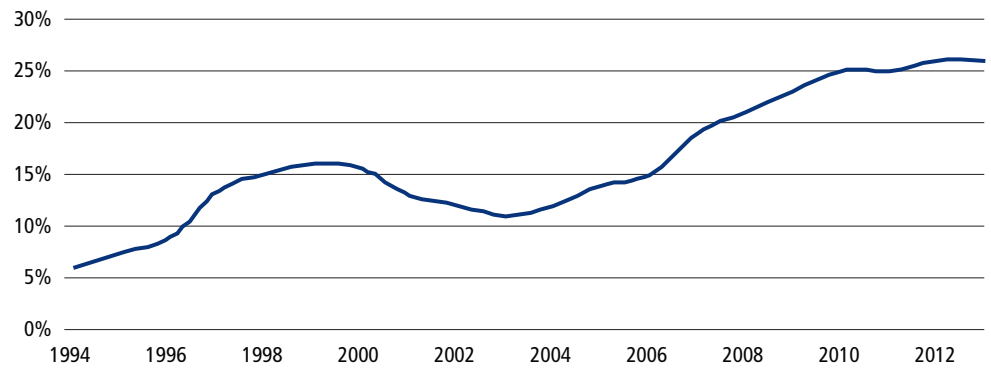
As of 2007, 10 percent of companies that provide health benefits to workers also offer a consumer-driven health plan (a high-deductible health plan with a health reimbursement arrangement and/or a health savings account-qualified high-deductible health plan).[39] The insurance industry estimates that 4.5 million people were enrolled in consumer-directed health plans in the employer and individual insurance markets in January 2007.[40] HSAs were promoted in the Federal Employees Health Benefits Plan as well. About 26,000 people were enrolled in these plans in 2007, and 32 insurers will offer such products to federal employees in 2008.[41]

The Bush administration also advanced consumer-directed health plans in public programs. Medical Savings Accounts, or MSAs, were made a permanent feature of Medicare in 2003. After three years in which no plans offered such policies, the administration used its demonstration authority to loosen program rules in 2006.[42] As of February 2007, Medicare MSA plans were offered in 38 states and the District of Columbia and enrolled 2,238 beneficiaries.[43] In 2008, such plans are available in all states.[44] Medicare subsidizes both the high-deductible plan and the accounts.

The Bush administration has also encouraged states to implement consumer-directed health plans in Medicaid. [45] It pursued a number of policies related to greater control over resources for individuals with disabilities. The Deficit Reduction Act of 2005 created a "Health Opportunity Account" demonstration program. Under this demonstration, up to 10 states could create accounts linked to high deductibles (up to $2,500 for adults) for Medicaid services. If the program is deemed successful after five years, the Secretary of Health and Human Services can extend it nationwide.

The Bush administration also approved demonstration waivers that allow for some types of accounts for health care.[46] The most recent, in Indiana, would use Medicaid funding to cover poor and near-poor

PRIVATE PLAN ENROLLMENT AMONG MEDICARE BENEFICIARIES
Percent of Hospital Insurance Enrollment



Source: Congressional Budget Office, Testimony, June 28, 2007.

adults in high-deductible plans linked to $1,100 accounts funded by the state and enrollees.[47] To date, very few people are enrolled in such demonstration plans.

Scaling Back Employer and Public Coverage

Parallel to its efforts to expand consumer-directed health plans, the Bush administration has scaled back group coverage in favor of individually based health insurance purchasing. It has proposed numerous policies to provide tax and other incentives to move people from employer to individual coverage.[48] None have been enacted. Regulatory changes, however, have allowed employers to make defined contributions to health reimbursement arrangements. Since these contributions may be used to purchase individual-market coverage, this offers employers a way to limit their liability and transition out of bearing responsibility for covering their workers.[49]

Conservative success has been greater in public programs. Historically, efforts to entice seniors to switch from traditional Medicare to private plans had limited success. To remedy this, the 2003 Medicare drug bill built in extra payments (in the form of taxpayer subsidies) for private plans that participate in the program. Since some of these extra payments are used to enrich benefits, enrollment in private plans increased over 60 percent between 2003 and 2007 (see chart above).[50]

The Medicare drug bill also created a premium support demonstration for 2010 that will cap funding for the traditional program. Since this would likely raise premiums for those who forgo enrollment in a private plan, it is a "stick" to complement the "carrot" of extra, subsidized benefits in Medicare private plans.[51]

In addition, the drug benefit itself is entirely delivered by private plans that receive a defined contribution for a loosely defined benefit. Medicare is prohibited from using its bulk purchasing power to negotiate for drug prices—a clear reflection of conservatives' faith in insurance market competition.

In Medicaid and the State Children's Health Insurance Program, or SCHIP, the Bush administration pursed two tracks: requiring greater use of private insurance and limiting program expansions. First, in July 2001, the administration announced the Health Insurance Flexibility and Accountability waiver initiative. This initiative expedited approval of so called Section 1115 demonstration waivers that included, among other policies, "premium assistance," or the use of public dollars to purchase private coverage.[52] Since then, the administration has made inclusion of premium assistance a prerequisite of every major Medicaid demonstration waiver.[53]

Second, it has limited Medicaid and SCHIP expansions. The Deficit Reduction Act of 2005 allowed states to raise cost-sharing and scale back benefits for certain beneficiaries.[54] This law, plus aggressive regulations, also limits enrollment by creating burdensome citizenship documentation requirements that states and Congress have tried, unsuccessfully, to ameliorate. The administration also opposed bipartisan Medicaid legislation to support states and unemployed people during economic slowdowns, insure low-income people affected by Hurricane Katrina, and give states options like covering low-income young adults and legal immigrant children.

Lastly, President Bush's veto of the bipartisan reauthorization of SCHIP in 2007 was justified by conservatives because of its failure to meet their health policy principles. The legislation included policies to continue and strengthen the program, including incentives to enroll eligible but uninsured children. CBO estimated that the SCHIP bill would insure nearly 4 million uninsured children and was well targeted.[55] The legislation had more bipartisan support than the Medicare drug benefit by far.[56]

The president, however, vetoed it twice, calling it "the beginning of the salvo of the encroachment of the federal government on the health care system."[57] His formal objection letter stated: "The bill is inconsistent with the principle of choice for American consumers and instead goes too far in federalizing health care. A competitive private market for health insurance is better policy than a government-run system that would mean lower quality, longer lines, and fewer options for patients and their doctors."[58] The president's veto was supported by Sen. McCain and the other the major Republican presidential candidates despite having a veto-proof majority in the Senate and 42 Republican votes in the House.[59]

New Proposals

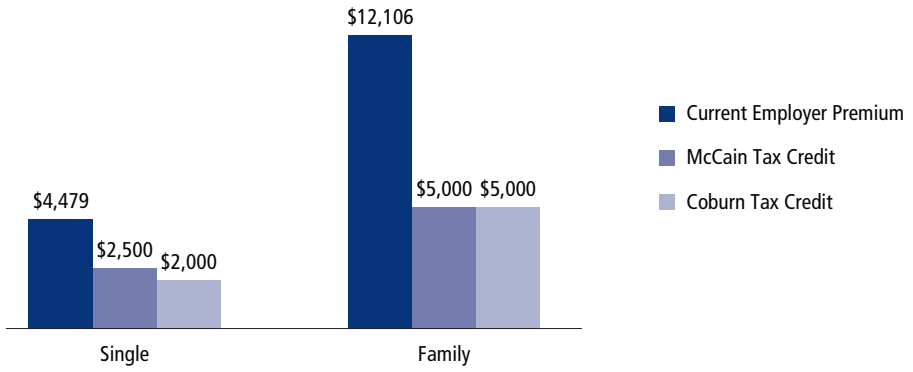
The proposals by some members of Congress and presidential candidates would not just advance but propel this conservative vision for the U.S. health system.[60] Proposals such as those from Sen. McCain on the campaign trail and Sen. Coburn in Congress (S. 1019) would expand the already generous incentives for HSAs. They would promote "shopping across state lines" for individual-market health insurance.[61] This effectively de-regulates insurance since it allows people to purchase plans sold in states with the least consumer protections.[62]

The major proposals of the Republican presidential candidates would also create more tax incentives for purchasing coverage through the individual market. Sen. McCain and former New York City

mayor Rudolph Giuliani (now out of the race) would repeal the current income tax exclusion for employer contributions to health benefits. McCain would replace the exclusion with a refundable tax credit of $2,500 for individuals and $5,000 for families—a voucher to purchase coverage through employers or the individual market (see chart below). The Giuliani plan resembled the president's budget proposal; it would have provided a tax deduction of up to $15,000 for health insurance, maintaining a subsidy that increases with income but capping the amount of that subsidy. These tax policy changes could catalyze a massive shift away from employer coverage to individual-market coverage.

Beyond promoting consumer-directed plans and individual-market coverage, the candidates would scale back public programs. None support expanding Medicaid or SCHIP. Sen. Coburn and former Massachusetts Governor Mitt Romney (also now out of the race) would block grant Medicaid, allowing the states to use the funds to expand private coverage. McCain would replace Medicaid with private insurance, giving states the options of supplementing the new tax credit. McCain supported the president's veto of the SCHIP reauthorization bill. It appears that all the conservative candidates support the Medicare policies advanced in the Bush administration to move Medicare toward a private-insurance-run, defined contribution program.

PREMIUM COSTS AND TAX CREDITS



Source: Kaiser Family Foundation/HRET, Employer Health Benefits 2007; proposals.

Impact of Conservatives' Health Reform on Access and Quality

The conservative vision for the health system—a vibrant marketplace with individual control through higher out-of-pocket payments and lower employer and government involvement—is a radical departure from the current system. In 2006, 94 percent of insured Americans were covered by either employer or public programs.[63] A wholesale shift to the individual market would mean a change in coverage for roughly 200 million Americans. Similarly, about 95 percent of covered workers in 2007 were in traditional group coverage rather than high-deductible plans.[64] Evidence on the impact of current trends and conservative proposals can be derived from early experiences with consumer-directed care and analogous experiences. This evidence raises a number of concerns.

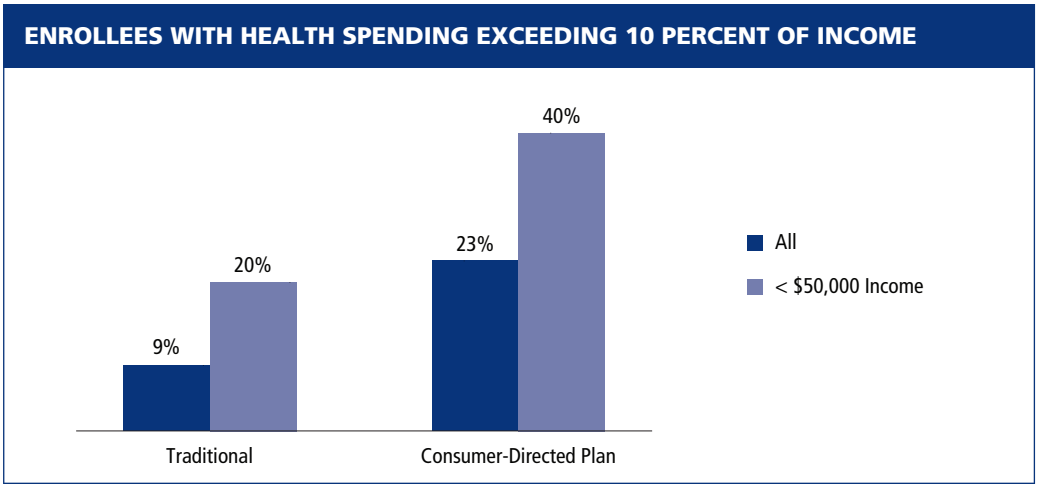
High Deductibles Could Lower Access and Health

A key plank of the conservative health platform is greater consumer responsibility and risk. Preliminary studies of consumer-directed health plans suggest that people enrolled in such plans do pay for a greater share of their health care costs. One survey found that, among people with employer-sponsored insurance, 23 percent of those in consumer-directed health plans reported paying more than 10 percent of their income on premiums and cost sharing, compared to only 9 percent of those in traditional plans (see chart, page 15).[65] Overall premiums also tend to be lower for employer-based high-deductible plans since cost is shifted to the deductible. In 2007, the deductibles averaged from $1,556 to $1,923 for single workers and $3,342 to $3,883 for families. While employer-based high-deductible plans linked to accounts are a critical component of the conservative vision, few employers actually contribute to them. One employer survey found that nearly half of all workers enrolled in consumer-directed plans had no employer contributions into these accounts.[66]

Early evidence suggests that such plans have lowered health care costs.[67] Yet this gain may be matched or exceeded by a different type of cost—reduced access to care and diminished health for people in need.

Discourages Use of Needed Care

Proponents of consumer-driven health care argue that cost sharing between the insured and insurer is needed to encourage cost consciousness, and that tax-subsidized accounts



Source: Commonwealth Fund/EBRI, 2006. Spending includes self-reported premiums and out-of-pocket spending.

will prevent cost-related access barriers. According to most studies, however, cost sharing discourages appropriate as well as inappropriate care—especially among the poor and sick.[68] This access pattern seems to persist for enrollees in high-deductible health plans. People enrolled in consumer-directed health plans were more cost conscious, but were also over 50 percent more likely to report some type of access problem related to cost.[69] Another survey found that people in high-deductible health plans were more likely than other privately insured adults to forgo filling a prescription due to cost.[70]

One of the major debates surrounding consumer-driven health care is whether it discourages prevention. More than half of enrollees in consumer-directed health plans reported having their deductible apply to prevention; the rate is higher among employer versus individual market plans.[71] When high-deductible plans cover prevention, not surprisingly, its use remains the same.[72] Yet deductibles and co-pays reduced the use of recommended clinical prevention such as Pap smears, mammography, and counseling services significantly among an insured, employee population.[73] A recent study of women enrolled in Medicare found that requiring them to pay $10 to $20 for a mammogram could reduce the proportion of women seeking them by 8 percent.[74]

The implications of high-deductible plans for people with potential or chronic health problems are particularly troubling. People with arthritis, heart disease, high cholesterol, and asthma were two to three times as likely to not fill a prescription due to cost when in a high-deductible plan versus a traditional insurance plan.[75] Employees in one study were roughly twice as likely to discontinue the use of statins and ACE inhibitors (used to manage high blood pressure and cholesterol) when their drug cost sharing was raised.[76] Evidence across the board suggests that managing chronic illness is complicated by high deductibles, cost sharing, and limits on benefits—risking health and raising costs.[77]

Depresses the Quality of Care

The early experience with consumer-directed care shows no real quality gains. Little information is given to enrollees in such plans on the quality of care and,

even when provided, it is not widely used.[78] A survey of insured people, irrespective of their plan types, found that only 11 percent to 21 percent of people used such information, with no change between 2001 and 2005 despite the growth of consumer-driven health plans.[79] In fact, one survey suggests that people in consumer-directed health care feel that they have less information on quality than those in comprehensive health plans.[80]

Satisfaction is one way to measure the quality of care and coverage. Only about 37 percent of people in consumer-driven health plans were extremely or very satisfied with their health plans, compared to 67 percent of those in traditional plans (see chart below). A different survey found that 44 percent of people enrolled in high-deductible plans were satisfied with their out-of-pocket costs compared with 69 percent of those in more traditional health plans.[81] Enrollees were also less likely to be satisfied with the quality of the actual health care that they receive.[82] This may reflect the types of choices people prefer. Generally, people value choice of providers, not choice of health plans or benefit design. One survey found that two-thirds of people would prefer an employer-selected set of plans over an employer-funded account and choosing insurance on their own.[83]

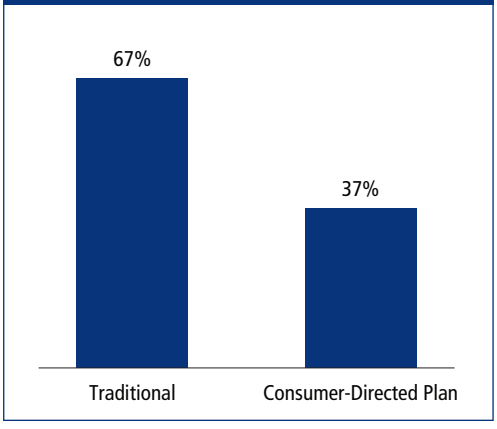
Shift from Group Insurance to Individual Insurance Market Could Diminish Coverage

An explicit goal of conservative health plans is to replace employer-sponsored and public health insurance programs with private, individual-market coverage. As described earlier, employer coverage has declined since 2000. This has not yielded more individual market enrollment; instead, it has raised the number of uninsured. Past may be prologue. The policies espoused by conservatives such as President Bush, the Republican presidential candidates, and their congressional allies would destabilize employer-based coverage but would do too little to make the individual market a viable alternative. As described below, this will likely result in less—and less reliable—health insurance coverage.

Undermines What Limited Protections Exist in the Individual Market

About 5 percent of non-elderly Americans are insured in the individual insurance policy marketplace. For more than half of such enrollees, it is a bridge from and to employer-based health insurance.[84] Because of its small size and nature, individuals have little leverage to secure high-value products. Coverage is often bare-bones; most plans in the individual market require a rider for coverage of maternity benefits, for example.[85]

ENROLLEES VERY OR EXTREMELY SATISFIED WITH THEIR PLAN



Source: Commonwealth Fund / EBRI, 2006.

What's more, cost sharing in individual insurance policies is higher than typical group insurance plans. Case in point: Older adults with individual insurance were nearly three times as likely as those in employer coverage to report paying more than $100 per month on drugs.[86] People in the poorest health spent nearly 20 percent of their income on health costs when individually insured, compared to 10 percent of income for those with employer coverage. In fact, both the uninsured and individually insured who have both low income and high costs spend roughly 50 percent of their income on health costs. This suggests that individual-market coverage provides weak financial protection.[87]

States historically have, through regulation, tried to protect consumers in the individual market. Yet state-level protections have declined in the past decade. In 2007, only five states prevented insurers from denying policies to individuals based on their history or characteristics. Only 18 states placed boundaries on the premiums that could be charged for applicants that may be at high risk.[88]

As a result, in most states, people with a need for health insurance have difficulty accessing affordable coverage in the individual-insurance market. One study based on simulated cases found that conditions such as asthma and hay fever could result in being denied access to individual-market insurance.[89] A survey found that over 70 percent of people in poor health found it very difficult or impossible to find affordable, individual-market coverage.[90] Another study using statistical corrections for selection bias found that, compared to people in excellent health, premiums in the individual market are 13 percent to 16 percent higher for people with modest health problems, and 43 percent to 50 percent higher for people with major health problems.[91]

President Bush and Republican presidential candidates would undermine what few state protections exist in the individual market by allowing individuals to shop for insurance across state borders. According to the Congressional Budget Office, "The shift of individuals expected to have relatively low health care costs to out-of-state insurance coverage would increase the price of coverage offered by insurers licensed in-state, and could lead to erosion of the availability of such coverage by insurers located in secondary states."

In other words, it would undermine the very market that the proposal strives to strengthen. It would also result in an estimated 1 million people losing employer-sponsored insurance as small businesses drop that coverage and healthy people leave it to buy cheap, out-of-state insurance.[92] While this would be offset by gains in coverage for some low-cost uninsured people, the net result is less insurance for people with health needs.

Puts Millions of Already-Insured People at Risk of Losing Coverage

Employer-sponsored insurance covers 61 percent of non-elderly Americans. Employers contribute to coverage primarily because of the tax incentive to do so. Conservative plans would eliminate this incentive and replace it with a tax break divorced from employers' contributions to coverage.

Irrespective of its design, this proposal would mean that all 160 million Americans who get the employer tax break today would get a different tax break under the plan, resulting in "winners" and "losers." Among people with employer-sponsored insurance today, a budget-neutral proposal would create more losers than winners since the new tax break credit goes to all insured people, not just those with employer coverage. Most experts agree—and many desire—that the result of repealing the tax exclusion would be a decline in job-based health insurance.[93]

Yet, a shift away from employer coverage to the individual market would cause some currently insured people to lose coverage altogether. Employer-based insurance charges the same premium to all workers and dependents, regardless of age or health risk—effectively pooling risk. Replacing employer coverage with individual-market coverage that allows for risk rating and denial of applications would make it hard for some workers losing employer coverage to re-gain it.[94]

The president's plan to replace the current tax break with a tax deduction for health insurance could cause 6 million to 12 million people with employer-based coverage to lose it; 1.3 million to 2.3 million of these people could become uninsured.[95] This loss of employer coverage would likely be greater under plans with tax credits than tax deductions. Tax credits provide a greater subsidy to low-income workers, making it easier for low-wage firms to drop coverage.

Conservative health reform would also erode employer coverage by drawing healthy workers into the individual insurance market and health savings accounts. The combination of tax breaks and low premiums due to medical underwriting would make individual-market insurance attractive to low-risk workers, even those with employer-sponsored coverage today. Similarly, health savings accounts have a design that appeals more to the healthy than to the sick. By raising deductibles, they lower premiums. Those with low medical expenses save due to the lower premium, but those with high expenses pay more in proportion to their costs.[96]

Reviews have found that people with health problems are, as expected, less likely to enroll in consumer-directed plans when given the choice.[97] An analysis of federal employees found that the average enrollee in consumer-driven plans was 13 years younger than the typical federal employee.[98] Similarly, individual-market insurance that bases premiums on risk is less expensive for healthy workers. If healthy workers leave traditional employer-sponsored insurance for HSAs or the individual market, then those left in employer coverage are sicker, on average. This raises premiums for employer-sponsored insurance, causing even more employers to drop it.

Worsens the Uninsured Problem

The conservative health tax proposals are typically as much about tax fairness and promoting certain types of health insurance as they are about covering the uninsured. HSA contributions and earnings are deducted from income tax based on a person's tax bracket. The greater the income, the greater the tax break. Indeed, enrollees in consumer-directed health plans generally have higher income.[99] For example, in the Federal Employee Health Benefits Plan, 43 percent of

people enrolled in HSAs had incomes of $75,000 or more, compared to 23 percent of all federal employees.[100] Employers themselves expect wealthier workers to enroll in HSAs.[101]

Similarly, President Bush's health insurance tax deduction of $7,500 for individuals and $15,000 for families benefits people with high income more than those with low income. Two-thirds of the uninsured have income below 200 percent of the poverty threshold ($21,200 for a family of four).[102] About 55 percent of the uninsured do not pay taxes due to low income.[103] Virtually no consumer-directed plans take into account the difference in health cost as a percent of income that low-income enrollees face.[104]

Some conservative plans, like those proposed by Sens. McCain and Coburn, provide refundable fixed-dollar tax credits. This ensures a benefit for people with little to no tax liability. However, the wealthiest American would get the same tax credit as the poorest American. Sen. McCain would require states to make some supplemental payment for high-risk or low-income individuals, but the details and sufficiency of this approach are unclear. Neither plan would adjust the credit for a person living in a high-cost area.

Some advocates contend that consumer-directed health plans offer less-expensive coverage, thus helping the uninsured gain coverage. While premiums do appear to be lower, little evidence points to gains in coverage. One survey found no significant difference in the percent of previously uninsured in consumer-directed than comprehensive plans.[105] This may be because of the design of HSAs linked to high-deductible health plans is not appealing to the uninsured—two-thirds of whom have income below 200 percent of the poverty threshold.

Given the low tax brackets that most uninsured face, the tax break associated with HSAs would only cover from zero to 6 percent of the premium. The most generous estimate of take up would be 401,000 people or less than 2 percent of the currently uninsured adult population.[106] Moreover, given the challenge low-income uninsured would face in paying for the deductible, the perceived value of the insurance to them may be low.[107]

The use of a flat or fixed dollar-amount tax credit, such as proposed in Coburn and McCain's health plan, could help people with low tax liability but not those with high health needs. If premiums were community rated—meaning that all enrollees were charged the same amount—then a flat tax credit would equally benefit low- and high-risk enrollees. Conservatives, however, oppose rate regulation. As such, insurers could, under their plans, base rates on the individual enrollees' risk. This means that a fixed credit would cover a smaller share of the premium for a high-risk than low-risk enrollee.

In addition, the separation of low-risk workers into health savings accounts in the individual market would make employer-based coverage for those who remain in it more expensive and thus less available. This can be seen by looking at President Bush's original tax credit proposal. In his budgets for FY 2001 through 2007, he proposed a flat $1,000 credit for singles, and up to $3,000 for families to purchase individual-market coverage. He also, in recent years, proposed expanding the tax breaks for high-deductible plans

linked to health savings accounts. An analysis of his FY 2007 budget proposals found that, while 3.8 million previously uninsured people might take up HSAs and individual-market coverage under the proposal, 8.9 million people would lose employer-sponsored insurance, and 4.4 million of them would become uninsured. On net, the number of uninsured Americans could actually rise by 600,000 under the president's proposal.[108]

Even under proposals that could result in a net gain in coverage, most analysts believe that composition of the uninsured population would change.[109] Some low-risk uninsured people might gain coverage, but high-risk individuals losing employer-based coverage could become uninsured. Already, nearly half (45 percent) of the non-elderly uninsured have at least one chronic condition.[110] One analyst examined the value of insurance given the person's age and health. He found that tax credits for individual coverage may have a low cost per newly insured person but have a high cost per dollar of insurance needed, since they disproportionately help the healthy.[111]

In short, conservative tax and individual market policies would do little to help the uninsured and could make solving the problem more difficult since the remaining uninsured population would be in worse health.

Impact of Conservative Health Plans on Health System Costs

A goal of virtually all health reform plans, conservative or progressive, is to contain the rapid rise of health care costs. The cost trajectory for public and private health spending threatens our budget and economy. Conservatives argue that this problem can be solved by creating a vibrant marketplace where individuals shop for health services and coverage from competing providers and insurers. But it is not clear that this theory works in practice.

Does Little to Affect Excessive Use and Price

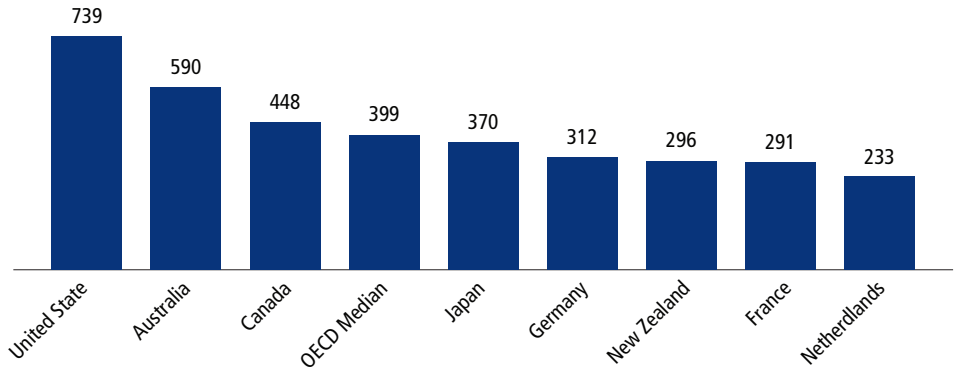
The health care cost equation is, in its simplest form, health care quantity (or use) times health care price. Conservatives argue that Americans consume too much and receive the wrong type of care. They believe that increasing cost exposure will reduce this use and thus costs. And they are confident that better, more efficient care will be the result.

The situation is not so simple. International comparisons rank the United States lower in use of hospital care, physician care, and prescription drugs than peer nations. The United States is a faster adopter of technology, but after its adoption, its use is not significantly different.[112] And our citizens already face high cost exposure. While the percent of total spending funded by individuals is lower than other nations, the average out-of-pocket spending per capita in the United States is twice that of other industrialized countries, and higher than all other nations, adjusting for cost of living (see chart, page 22).[113]

International comparisons mask the fact that there are two Americas when it comes to health care. Patterns for insured versus uninsured people are markedly different, and insured people in the United States may be over-insured. Yet even just focusing on the insured population raises questions about whether high-deductible health plans will lower high-cost use of care. After the deductible is reached, people typically pay low to no cost sharing for care. People whose spending exceeds the HSA deductible account for more than 95 percent of medical expenditures.[114]

As such, the deductible may reduce prevention and chronic care management for low-cost people, but will do little to affect the spending for people whose costs quickly exceed the deductible. In addition, the experience from flexible health savings accounts suggests that these accounts may fund services that would not otherwise be paid for by traditional health insurance. This may be especially true in health savings accounts that have low penalties for withdrawals for non-health care spending.[115]

OUT-OF-POCKET HEALTH SPENDING PER CAPITA, 2003



Source: Frogner, Commonwealth Fund, 2006. Adjusted for cost of living

There is also evidence that competition may not lower prices under a full-blown, consumer-driven system. At the individual service level, some price competition exists in specific instances, for example in generic drug substitutes or cosmetic surgery. Price information, however, is not easily accessible or usable in the current system. It is often not a consideration for a person with a clear need for a recommended service.[116]

Moreover, evidence suggests that major health service providers charge higher, not lower, rates to people who pay for care out of pocket. For instance, a recent study of hospital pricing in California found that the uninsured paid more for hospital care than did Medicare, Medicaid, and some commercial insurers.[117] Another found that people who "self pay" at hospitals were charged 2.5 to 3 times as much as private insurers and Medicare, a gap that has increased since the 1980s (see chart, page 23).[118] The power of suppliers in health care, especially for essential health care, casts doubt on whether individuals' shopping for prices can successfully lower costs.

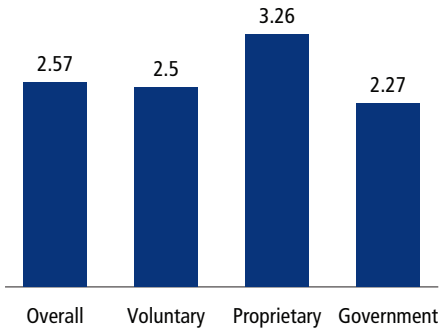
At the insurance level, some competing plans that use provider networks, tiered cost sharing, and other management tools have been able to lower prices as well as costs. But this experience is limited, and some payers in the system are skeptical about the potential of market competition to reduce costs.[119]

Skepticism is even greater when it comes to the individual market. It is hard to determine what insurance plans are available at what cost in the individual market today. It would be even harder if people could shop for insurance in any state. Since individual insurers have greater control over who enrolls than group insurers, they can compete on limiting their exposure and avoiding risk. In California, for example, one insurer linked employee bonuses to cancellation of policies for people who incur high health costs.[120]

Insurers also design health benefits to attract low-risk individuals. Some cover teeth whitening and gym membership but have high deductibles and limited coverage of expensive services.[121] A review of individual market coverage found that insurers were significantly less likely to cover prescription drugs or mental health services compared to group health insurance plans.[122]

In addition, there has been a consolidation of the health insurance industry in the United States. The largest insurer covers one-third of the market in 38 states, and one-half of the market in 16 states.[123] Insurers are unlikely to lower their premiums even under a full consumer-driven model if they have little to no competition. Some of these problems could be addressed through antitrust enforcement as well as greater rules and oversight of insurers' practices, but conservatives' health plans tend to reject regulation.

MARK-UPS IN HOSPITAL PRICING
Total Charges / Total Costs, 2004



Source: Anderson, *Health Affairs*, 2007.

Raises Administrative Costs

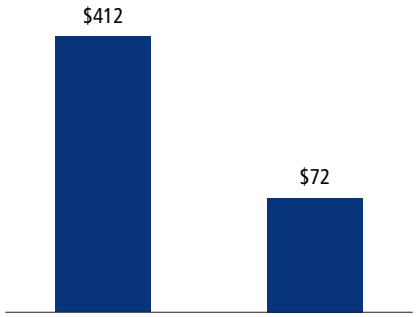
If vigorous competition results in lower prices and appropriate use of care, then the attendant administrative costs—marketing, overhead, and the risk premium—might be offset. If competition does little to reduce costs, however, then such administrative costs are wasteful.

The government estimates that about $180 billion will be spent in 2008 on public and private insurance administrative activities.[124] A study that pulled out the administrative costs embedded in each type of service estimated that about 30 percent of every dollar spent on health care in the United States is associated with administrative costs.[125] Compared to other nations, this is two to three times higher.[126] Adjusting for the ability of nations to spend on health care, a different study estimated that the administrative cost of health care in the United States is $412 per person, compared to $72 per person in peer nations—a sixfold difference (see chart, page 24).[127]

Competition under conservative plans would raise administrative costs, since advertising, frequent switching of plans, and rapid changes in product design are integral to functioning markets. There would also be costs to the individual of tracking expenditures that qualify for funding from the HSA. Moreover, the administrative costs of individual health insurance are high. Such costs account for 25 percent to 40 percent of the premium dollar compared to roughly 10 percent for employer-based coverage.[128] Thus, a shift to an individual-market system could add tens if not hundreds of billions to our health system costs for administration alone.

The same is true in public programs. The extra payments that private plans claim to need to participate in Medicare raise costs by nearly $150 billion over the next 10 years, according to the Congressional Budget Office.[129] While some of this excess funds extra benefits, the idea that the public has to pay more for competition runs counter to the theory. This policy shortens the life of the Medicare Trust Fund and raises the premiums of those in the traditional program[130] This is a clear case of how conservative health care reforms could raise rather than lower health costs.

ADMINISTRATIVE COSTS PER CAPITA, ADJUSTED FOR NATIONS' WEALTH



Source: McKinsey Global Institute, 2007. Compared to OECD nations.

Another less studied but potentially costly effect of consumer-driven health care is the movement of coverage from self-insured companies—in which an employer assumes the financial risk for providing employee health benefits—to the fully-insured individual market, in which people pay fixed premiums to insurers that bear the financial risk. In 2007, a majority of covered workers (55 percent) were in self-funded plans.[131]

Companies that self-fund their health benefits do not create the type of insurance reserves for this coverage that fully-insured plans do, although many purchase re-insurance to protect against large, unexpected losses. Doubling the number of people in fully-insured individual plans would be a boon for the insurance industry. It would collect and manage premium revenue for tens of millions more Americans. This would give insurers more power on Wall Street as well as in the health system. And it could raise administrative costs if insurers risk premiums for this market exceed what self-insured firms had been paying.

The conservative approach to health reform would also create a new health care "industry," and that would be banking. The management of accounts (fees, start-up costs, and management costs) is not cost free.[132] As one consulting report stated, "Over the next five years, financial institutions have the potential to capture $3.5 billion in revenues driven by account and asset manager fees. Health payment processors stand to earn $2.3 billion in processing fees over the same period."[133]

A recent article documented the emergence of health cost credit cards since most high-deductible plans are not linked with well-funded accounts. Interest rates for some of these accounts can be as high as 27 percent, and a number of major as well as smaller banks are entering the market.[134]

Diminishes Effectiveness of Cost Savings Initiatives

As stated earlier, the problems of health access, quality, and costs are interconnected. So too are the solutions. A failure to promote quality affects health care costs. Numerous studies support the fact that high-quality care can be delivered at a lower cost.[135] Consumer-driven health care's poor record to date on increasing the quality of care could exacerbate the cost problem.

The further fragmentation of the U.S. health system under conservative plans also adds to health system costs. Within the public sector alone, there are 50 different Medicaid programs, state employee health benefit systems, and commercial insurance regulatory schemes—plus Medicare, the Veterans'

Administration, and insurance programs for federal employees. This complexity adds tens of billions of dollars to our system costs that are avoided by our competitor nations.[136]

Yet complexity would rise, not fall, under conservative health reform. It would replace employer and public insurance programs with individual-market insurance with no uniform standards. As one analyst described it, "Indeed, there is evidence that encouraging people to join such health plans might act as salt on a wound, exacerbating some of the very maladies that undermine our health care system's ability to perform at the highest level."[137]

Conservative health plans' tolerance of leaving millions of Americans uninsured also has cost implications. Even if their proposals reduce the number of uninsured, the remaining uninsured will have greater needs and costs as the healthy are preferentially granted access to coverage. This is especially true in voluntary proposals with fewer individual-market rules than exist today.[138]

Because premiums in the individual market can be set based on health status, history, or age, a fixed-dollar tax credit covers a larger share of the lower premium for healthy than unhealthy uninsured and insured workers alike. If healthy workers and uninsured migrate to the individual market, the pool of uninsured would become sicker. A sicker pool of uninsured Americans would increase the "cost shifting" that occurs when health providers pad the costs of care for insured people to offset the uncollected bills for care for the uninsured. One analysis estimated that this added $922 to the premium for a privately-insured family in 2005.[139]

A sicker pool of uninsured Americans would also increase the lost productivity that results from lack of coverage. The Institute of Medicine calculated this economic loss at $65 to $130 billion per year,[140] an amount that would likely grow with the erosion of employer and public coverage and the worsening health status of the typical uninsured American.

Fragmentation and gaps in coverage under conservative plans would also limit the potential of policies to bend the growth curve in health costs. There is widespread, bipartisan agreement that improved prevention, chronic disease management, health information technology, and similar policies could reduce the growth in the nation's health costs. Complete, routine childhood vaccinations, for example, could save up to $40 billion in direct and societal costs over time.[141] Aggressive, continuous management of diabetes, in one setting, resulted in improved health as well as costs that were lower by over $1,000 per person each year.[142]

But the full potential of these preventive policies to realize savings may be constrained or even reversed if one-third of the population cycles in and out of insurance over the course of two years.[143] The gains from coordination and appropriate care can be quickly lost if a person forgoes health care because of lack of coverage. As one economist wrote, "Covering nearly all Americans is a precondition for effective measures to limit overall health care spending."[144]

In short, applying cost sharing in a targeted way rather than through an arbitrary high deductible could promote access and quality as well as efficiency.[145]

Conclusion

Contrary to popular opinion, conservatives' approach to health care is not to ignore it. They have put forth theories and policies. Under President Bush, they have put many of them into place. And contrary to some single-payer advocates, the conservative approach to health care contains some elements that could work.

There is indeed a critical role for choice in all health reform plans. Individuals should have options when it comes to who to see and what to get and what to pay for health care. Individuals, like other actors in the system, should also bear some responsibility for their own care and the system's performance. The goal of reform is to improve the health of individuals, and health involves individual actions—from prevention to seeking care when needed to following a course of treatment to getting insurance.

In addition, competition applied in a targeted way can advance health system goals in progressive as well as conservative plans. Most progressive plans include competing private insurers. And virtually all health plans support greater information and use of information technology, both key elements to well-run markets.

Yet conservatives' theory on health care is flawed even though some of its elements may be sound. The blunt application of standard economics to health care has been rejected by many economists. As one put it, seeking health care "…isn't at all like buying clothing."[146] Health care is ultimately about preserving life and delaying death; putting a price on survival is difficult for many.[147]

The need for health care is also defined, in part, by the supplier: physicians. Individuals typically initiate a health care visit, but its content and follow-up are largely determined by the doctor. Patients have input and choices, but physicians have greater information and control in most circumstances. In addition, health care cannot be purchased in $1,000 increments; the product is complex and changes rapidly.[148] As one commentator described it, consumer-driven health care is analogous to buying a car and having the parts delivered to your front yard for assembly.

On the insurance side, the conservative theory scales back the social redistribution of health care costs that insurance can achieve.[149] Its "ownership society" shifts risk from groups to individuals by design. As one expert concluded, "A wholesale switch to HSAs would redistribute the nation's overall financial burden of health care from the budgets of chronically healthy families to those of chronically ill families."[150] These concerns about conservative theory cannot be mitigated by policy design.

The flaws in the plan to implement the theory can be seen by comparing it to a Medicare drug benefit that many conservatives claim as a success.

Under the drug benefit, Medicare contributes an amount to the purchase of drugs based on the cost of coverage, not an arbitrary, flat tax credit as in the McCain or Coburn plan. The deductible for drug plans cannot exceed $275; the conservative health reform plans promote plans whose deductibles are anywhere from four to 20 times this amount. Drug plans must offer all applicants coverage and charge each one the same rate; McCain and Coburn would allow individual insurers to deny coverage and charge each enrollee a different rate. The drug plan has its flaws, but using it as a conservative "yardstick," McCain and other conservatives' health plans seem to put ideology over practicality.

In summary, conservative health proposals such as those espoused by President Bush and Senator McCain are both radical and dangerous. Eliminating the current tax subsidy for health insurance and replacing it with a new one would dramatically change the way that nearly 160 million Americans get coverage. Workers could lose employer-based coverage without gaining an affordable, accessible alternative source of coverage. High-deductible plans in a de-regulated individual insurance market would shift costs to the poor and sick. And flawed theory and design in tandem could actually raise health system costs, exacerbating the cost crisis in the health system.

Sound alternatives exist. The Center for American Progress has proposed one such plan. Our "Progressive Prescriptions" plan would:

- Build on private and public group health coverage
- Ensure access through insurance reforms and sliding-scale subsidies
- Rein in cost through policies such as prioritized prevention, health information technology, and comparative effectiveness research
- Promote shared responsibility, where individuals, providers, and payers all participate in making the system work[151]

This solution is similar to what was enacted in Massachusetts in 2006 with bipartisan support. Already, this plan has enrolled 245,000 people, making a significant dent in the state's uninsured rate.[152] Our progressive health reform framework has been adopted by the leading progressive candidates for president. There is a common-sense solution to the health system crisis. It can be achieved if practicality is prioritized over ideology.

Endnotes

1 R. Teixeira, "Public Opinion Snapshot: Americans Agree, Time for Action on Health Care," January 18, 2008, available at http://www.americanprogress.org/issues/2008/01/opinion_health (last accessed January 21, 2008).

2 Office of the Actuary, Centers for Medicare and Medicaid Services, National Health Expenditure Data for 2006. U.S. Department of Health and Human Services, available at: http://www.cms.hhs.gov/NationalHealthExpendData/ (last accessed January 21, 2008).

3 Organisation for Economic Co-Operation and Development, "OECD Health Data 2007," available at: http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (last accessed March 1, 2008).

4 P.R. Orszag, "Testimony: Growth in Health Care Costs," United States Senate Committee on the Budget, January 31, 2008.

5 Better Health Care Together, "Health-Cost Crossroad: Why American Businesses Urgently Need Health System Reform," January 11, 2008, available at: http://www.betterhealthcaretogether.org/Library/docs/BHCT%20Issue%20Brief%20 01-11-08.pdf (last accessed January 21, 2008).

6 Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey." (Menlo Park, CA: Kaiser Family Foundation, 2007).

7 Ibid.

8 McKinsey, "Will Health Costs Eclipse Profits?" McKinsey Quarterly, September 2004, Chart Focus Newsletter.

9 L.H. Teslik, "Healthcare Costs and U.S. Competitiveness," Council on Foreign Relations, May 14, 2007, available at: http://www.cfr.org/publication/13325/ (last accessed on January 21, 2008).

10 Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey."

11 J.S. Banthin, P. Cunningham, and D.M. Bernard, "Financial Burden of Health Care, 2001-2004," Health Affairs 27 (1) (2008): 188–195.

12 D.U. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," Health Affairs, Web Exclusive, W5-63-W5-73, February 2, 2005.

13 Employee Benefit Research Institute, "Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement" (Washington, DC: EBRI Issue Brief #295, July 2006).

14 U.S. Census Bureau, Historical Health Insurance Tables, 2007, available at: http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html (accessed January 21, 2008).

15 J.A. Rhoades and S.B. Cohen, "The Long-Term Uninsured in America, 2002-2005" (Rockville, MD: U.S. DHHS, AHRQ, Statistical Brief #183, August 2007).

16 Better Health Care Together, "Health-Cost Crossroad: Why American Businesses Urgently Need Health System Reform."

17 J. Holahan and A. Cook, "What Happened to the Insurance Coverage of Children and Adults in 2006?" (Menlo Park, CA: Kaiser Family Foundation, October 2007).

18 U.S. Census Bureau, Historical Health Insurance Tables, 2007, available at: http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html (accessed March 9, 2008).

19 Kaiser Family Foundation, "The Uninsured: A Primer, Key Facts about Americans without Health Insurance" (Menlo Park, CA: Kaiser Family Foundation, 2007)

20 Ibid.

21 Ibid.

22 J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintended Injury or the Onset of a Chronic Condition," JAMA 297 (10) (2007): 1073-1084.

23 S. Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality" (Washington, DC: The Urban Institute, 2008).

24 Federal Bureau of Investigations, "Crime in the United States: 2006" (Washington, DC: U.S. Department of Justice, 2007), available at: http://www.fbi.gov/ucr/cius2006/offenses/violent_crime/murder_homicide.html (accessed January 21, 2008).

25 E. McGlynn et al., "The Quality of Care Delivered to Adults in the United States," New England Journal of Medicine 348 (26) (2003): 2634-2645.

26 C. Schoen et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Nations," Health Affairs Web Exclusive,W5-509-525, November 3, 2005.

27 G.F. Anderson et al., "Health Care Spending and Use of Information Technology in OECD Countries," Health Affairs 25(3) (2006): 819-831.

28 Institute of Medicine, To Err is Human: Building a Safer Health Care System (Washington, DC: National Academies Press, 2000).

29 E. Nolte and C.M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," Health Affairs 27 (1) (2008): 58-71.

30 A.L. Kellerman, "Crisis in the Emergency Department," New England Journal of Medicine 355 (13) (2006): 1300-1303..

31 A.P. Wilper, "Waits to See an Emergency Department Physician: U.S. Trends and Predictors, 1997-2004," Health Affairs Web Exclusive w84-w95, January 15, 2008.

32 Kaiser Health Tracking Poll: Election 2008, December 2007, available at: http://www.kff.org/kaiserpolls/upload/7728.pdf (last accessed January 21, 2008).

33 D. Boaz, "Defining an Ownership Society" (Cato Institute, undated) available at http://www.cato.org/special/ownership_society/boaz.html (last accessed January 22, 2008).

34 Americans for Free Choice in Medicine, "Brief History of Health Savings Accounts (HSAs)," available at: http://www.afcm.org/hsahistory.html

35 C. Marshner, "Health Insurance Reform: What Families Should Know," WebMemo No. 1739, December 13, 2007.

36 For example, MSAs were a centerpiece of House Minority Leader Robert Michel's Affordable Health Care Now Act of 1994 (HR 3080).

37 J.C. Goodman, "Statement on Health Savings Accounts," Senate Finance Committee Subcommittee on Health, September 26, 2006.

38 Kaiser Family Foundation, "Health Insurance Coverage in America: 2006 Data Update" (Menlo Park, CA: Kaiser Family Foundation, 2007).

39 Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey."

40 Center for Policy and Research, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans" (Washington, DC: America's Health Insurance Plans, 2006).

41 Office of Personnel Management, "OPM Holds Average FEHBP Premium Increase to about Two Percent for the Second Year," Press Release, September 13, 2007, available at: http://www.opm.gov/news/opm-holds-average-fehb-premium-increase-to-about-two-percent-for-second-year,1324.aspx (last accessed January 26, 2008).

42 B. Fuchs and L. Potetz, "Medicare Consumer-Directed Health Plans: Medicare MSAs and HSA-Like Plans in 2007" (Menlo Park, CA: Kaiser Family Foundation Issue Brief, 2007).

43 MedPAC March 2007, Kaiser Family Foundation. (February 2007). MedicareAdvantage Fact Sheet, available at http://www.kff.org/medicare/upload/2052-09.pdf

44 Department of Health and Human Services, FY 2009 Budget in Brief (Washington, DC: DHHS, 2008).

45 J. Greene, "State Approaches to Consumer Direction in Medicaid" (Hamilton, NJ: Center for Health Care Strategies Issue Brief, 2007).

46 C. Milligan, C. Woodcock, and A. Burton, "Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing" (Washington, DC: State Coverage Initiatives, AcademyHealth, 2006).

47 J. Solomon, ". Paying More for Less: "Healthy Indiana Plan" Would Cost More Than Medicaid While Providing Inferior Coverage" (Washington, DC: Center on Budget and Policy Priorities, 2008).

48 Examples are in each of the president's budget proposals, including a tax credit for low-income people to purchase coverage in the individual market (in the president's FY 2002 through 2007 budgets) and a new deduction for this coverage (in the president's FY 2008 and 2008 budgets).

49 J. Appleby, "Employers Put Workers Coverage in their Own Hands," USA Today, January 24, 2008.

50 Kaiser Family Foundation, Medicare Health and Prescription Drug Plan Tracker, available at: http://www.kff.org/medicare/healthplantracker/index.jsp (last accessed January 25, 2008).

51 T. Rice and K.A. Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," Journal of Health Policy, Politics, and Law, 29 (6): 1187-1226.

52 Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," U.S. Department of Health and Human Services, August 4, 2001.

53 C. Shirk and J. Ryan, "Premium Assistance Under Medicaid and SCHIP: Ace in the Hole or House of Cards?" (Washington, DC: National Health Policy Forum, Issue Brief No. 8, 2006)

54 S. Parrott, E. Park, and R. Greenstein, "Assessing the Effects of the Budget Conference Agreement on Low-Income Families" (Washington, DC: Center on Budget and Policy Priorities, 2006).

55 Congressional Budget Office, Cost Estimate, H.R. 976 (Washington, DC: Congressional Budget Office, 2007).

56 J. Lambrew, "Congress Should Override the Bush Double Standard on Children's Health" (Washington, DC: Center for American Progress, 2008).

57 R. Wolf and D. Jackson, "Senate Panel OKs $35B Increase for Kids' Health Care," USA Today, July 19, 2007.

58 Office of Management and Budget, Statements of Administration Position, S. 1893, July 30, 2010.

59 A. Aigner-Treworgy et al., "Leading GOP Contenders Lining Up with Bush on SCHIP," Congress Daily, October 3, 2007; R. Pear, "Veto Stands on Measure to Expand Health Plan," The New York Times, January 24, 2008.

60 For reviews of the candidates' health plans, see the S.R. Collins and J.L. Kriss, "Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposal" (New York: The Commonwealth Fund, 2008); Kaiser Family Foundation, "2008 Presidential Candidate Health Care Reform Proposals: Side-by-Side Summary," available at http://www.health08.org/sidebyside.cfm; and the New York Times "Health Care Issues" webpage, available at: http://politics.nytimes.com/election-guide/2008/issues/index.html#/context=index/issue=health.

61 This is modeled on HR 2355, The Health Care Choice Act that Representative Shadegg has previously proposed and President Bush supported.

62 E.A. Pendo, "The Health Care Choice Act: The Individual Market and the Politics of 'Choice'," Western New England Law Review, 29: 471 (2007); M. Kaufman and K. Pollitz, "Health Insurance Regulation by States and Federal Government: A Review of Current Approaches and Proposals for Change" (Washington, DC: Georgetown University, 2006); Families USA, "H.R. 2355, The Health Care Choice Act: A Bad Prescription for America's Health Care Needs," August 2006, available at: http://www.familiesusa.org/assets/pdfs/bad-ideas-shadegg-hr-2355.pdf (last accessed January 27, 2008);

63 Kaiser Family Foundation, "Health Insurance Coverage in America: 2006 Data Update."

64 Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey."

65 P. Fronstin and S.R. Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey: Early Experience with High-Deductible Health Plans" (Washington, DC: Employee Benefit Research Institute, Issue Brief No. 300, 2006).

66 Kaiser Family Foundation / Health Research and Educational Trust, "Employer Health Benefits 2007". (Menlo Park, CA: Kaiser Family Foundation, 2007).

67 M. Beeuwkes et al., "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality," Health Affairs, 25 (6) (2006): W516-30.

68 See, for example, J.P. Newhouse. Free for All? Lessons from the Rand Health Insurance Experiment. (Cambridge: Harvard University Press, 1993); Beeuwkes et al., "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality.".

69 Fronstin and Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey: Early Experience with High-Deductible Health Plans ."

70 T.H. Lee and K Zapert, "Do High-Deductible Health Plans Threaten Quality of Care?" New England Journal of Medicine, 353 (12) (2005): 1202-4.

71 Fronstin and Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey: Early Experience with High-Deductible Health Plans."

72 J. Rowe et al., "The Effect of Consumer-Driven Health Plans on the Use of Prevention and Chronic Illness Services," Health Affairs, 27 (1) (2008): 113-120.

73 G. Solanki, H.H. Schauffler, and L.S. Miller, "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services. Health Services Research 34 (6) (2000): 1331-51.

74 A.N. Trivedi et al., "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans," New England Journal of Medicine, 358 (4) (2008): 375-383.

75 Lee and Zapert, "Do High-Deductible Health Plans Threaten Quality of Care?"

76 H.E. Huskamp et al., "The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending," New England Journal of Medicine, 349 (23) (2003): 2224-32.

77 K. Thorpe, "Cost Sharing, Caps on Benefits, and the Chronically Ill – A Policy Mismatch," New England Journal of Medicine, 354 (22) (2006): 2385-86.

78 Beeuwkes et al., "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality.".

79 Lee and Zapert, "Do High-Deductible Health Plans Threaten Quality of Care?"

80 Fronstin and Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey: Early Experience with High-Deductible Health Plans."

81 Lee and Zapert, "Do High-Deductible Health Plans Threaten Quality of Care?".

82 Fronstin and Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey: Early Experience with High-Deductible Health Plans."

83 J. Lambrew, "Choice" in Health Care: What Do People Really Want?" (New York: The Commonwealth Fund, 2005).

84 E.C. Ziller et al., "Patterns of Individual Health Insurance Coverage, 1996-2000," Health Affairs, 23 (6) (2004): 210-21.

85 S.R. Collins, S.B. Berkson, and D.A. Downey, "Health Insurance Tax Credits: Will They Work for Women?" (New York: The Commonwealth Fund, 2002).

86 E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," Health Affairs 20 (4) (2001): 139-49.

87 L.J. Blumberg, L. Clemans-Cope, and F. Blavin, "Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs" (Washington, DC: The Urban Institute, 2005).

88 Kaiser Family Foundation, "Statehealthfacts.org," available at: http://www.statehealthfacts.org/index.jsp (last accessed January 28, 2008).

89 K. Pollitz and R. Sorian, "Perspective: Is the Individual Market Ready for Prime Time?" Health Affairs, W372-76, October 23, 2002.

90 S. Collins et al., "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families" (New York: The Commonwealth Fund, 2006).

91 J. Hadley and J.D. Reschovsky, "Health and the Cost of Non-Group Insurance," Inquiry, 40 (3) (2003): 235-53.

92 Congressional Budget Office, "Cost Estimate: H.R. 2355: The Health Care Choice Act of 2005," (Washington, DC: CBO, 2005).

93 L.E. Burman et al., "The President's Proposed Standard Deduction for Health Insurance." (Washington, DC: The Urban Institute Tax Policy Center, 2007); J.M. Lambrew, "The Tax Exclusion for Health Benefits: The Loose Thread," Tax Notes, 1265-1266, June 12, 2006.

94 E. Park E. and J. Furman, "President's Health Care Tax Cut Proposals Are Likely to Weaken Employer-Based Health Insurance. (Washington, DC: Center on Budget and Policy Priorities, 2006); L. Burman and J. Gruber, "Tax Credits for Health Insurance," Tax Policy Center Discussion Paper No. 19. (Washington, DC: The Urban Institute, 2005).

95 Congressional Budget Office, An Analysis of the President's Budgetary Proposals for Fiscal Year 2008 (Washington, DC: CBO, 2007); J. Sheils and R. Haught, "President Bush's Health Care Tax Deduction Proposal: Coverage, Cost and Distributional Analysis" (Falls Church, VA: The Lewin Group, 2007).

96 P. Ginsburg, "Tax Free but of Little Account," Modern Healthcare, February 16, 2004.

97 Beeuwkes et al., "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality."

98 Government Accountability Office, Federal Employees Health Benefit Plan: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts. (Washington, DC: U.S. GAO, GAO-06-271, 2006).

99 Beeuwkes et al., "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality."; A. Minicozzi, "Medical Savings Accounts: What Story Do the Data Tell?" Health Affairs 25 (1) (2006): 256-267.

100 Government Accountability Office, Federal Employees Health Benefit Plan: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts.

101 Mercer Human Resource Consulting. (2004). "US Employers See a Role for New Health Savings Accounts in their Benefit Programs." New York: Mercer, available at: http://www.mercerhr.com/

102 Kaiser Family Foundation, "The Uninsured: A Primer, Key Facts about Americans without Health Insurance.").

103 S. Glied and D. Remler, "The Effects of Health Savings Accounts on Health Insurance Coverage" (New York, The Commonwealth Fund, 2005).

104 M. Rosenthal, C. Hsuan, and A. Milstein, "A Report-Card on the Freshman Class of Consumer-Directed Health Plans," Health Affairs, 24 (6) (2005): 1592-1600.

105 Fronstin and Collins, "The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey: Early Experience with High-Deductible Health Plans."

106 S. Glied and D. Remler, "The Effects of Health Savings Accounts on Health Insurance Coverage."

107 S. Glied, "Is Something Better than Nothing? Health Insurance Expansions and the Content of Coverage," in D.M. Cutler and A.M. Garber, eds., Frontiers in Health Policy Research, Volume 6. (Cambridge, MA: MIT Press, 2003).

108 J. Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals." (Washington, DC: Center on Budget and Policy Priorities, 2006).

109 Congressional Budget Office, "Appendix C: The President's Proposal for a Standard Tax Deduction for Health Insurance," An Analysis of the President's Budgetary Proposals for Fiscal Year 2008. (Washington, DC: CBO, 2007).

110 Urban Institute and the University of Maryland, Baltimore County, "Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey." (New Jersey: Robert Wood Johnson Foundation, 2005).

111 J. Gruber, "Covering the Uninsured in the U.S.: NBER Working Paper Series." Working Paper 13758 (Cambridge, MA: National Bureau of Economic Research, ,2008).

112 G.F. Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," Health Affairs 23, (3) (2004): 10-25.

113 B.K. Frogner and G.F. Anderson, "Multinational Comparisons of Health System Data, 2005" (New York: The Commonwealth Fund, 2006).

114 L. Blumberg and L.E. Burman, "Most Households' Expenditures Exceed HSA Deductible," Tax Analysts Tax Facts, Tax Notes, August 16, 2006.

115 E. Park, "Health Savings Accounts Unlikely to Significantly Reduce Health Care Spending" (Washington, DC: Center on Budget and Policy Priorities, 2006).

116 J. Appleby, "Shopping for Health Care Prices Can Be Pretty Confusing," USA Today, May 9, 2006.

117 G.A. Melnick and K. Fonkych, "Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?" Health Affairs, Web Exclusive, W116-122, February 5, 2008.

118 G. Anderson, "From Soak the Rich to Soak the Poor: Recent Trends in Hospital Pricing," Health Affairs, 26 (3) (2007): 780-89.

119 L.M. Nichols et al., "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems?" Health Affairs 23 (2) (2004): 8-21.

120 L. Girion, "Health Insurer Tied Bonuses to Dropping Sick Policyholders," The Los Angeles Times, November 9, 2007.

121 M.P. McQueen, "Health Insurers Target the Individual Market," The Wall Street Journal, August 21, 2007.

122 J. Gabel et al., "Individual Insurance: How Much Financial Protection Does It Provide?" Health Affairs, Web Exclusive, April 17, 2002.

123 J.C. Robinson, "The Consolidation and Transformation of Competition in Health Insurance," Health Affairs, 23 (6) (2004): 11-24.

124 National Health Accounts, projections, available at: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf (access on February 12, 2008).

125 S. Woodlander, T. Campbell, D. Himmelstein, "Costs of Health Care Administration in the U.S. and Canada," The New England Journal of Medicine, August 21, 2003.

126 U.E. Reinhardt et al., "U.S. Health Spending in an International Context," Health Affairs 23 (3) (2004): 10-25.

127 McKinsey Global Institute, "Instititue, Accounting for the Cost of Health Care in the United States" (New York: McKinsey, 2007).

128 M.V. Pauly and L.M. Nichols, "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes," Health Affairs, W325-44, October 23, 2002; Gabel et al., "Individual Insurance: How Much Financial Protection Does It Provide?" Health Affairs.

129 P. Orszag, "Testimony: The Medicare Advantage Program," U.S. House of Representatives, Committee on the Budget, June 28, 2007.

130 Congressional Budget Office, Medicare Advantage: Private Health Plans in Medicare: CBO Economic and Budget Issue Brief. (Washington, DC: Congressional Budget Office, 2007).

131 Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey."

132 E. Dash, "Wall Street Senses Opportunities in Health Savings Accounts," The New York Times, January 27, 2006, p. A1.

133 A. Baig, J. Nuckols, and A. Dawson, "Insight: Seizing the HSA Opportunity: Developing a Winning Strategy to Grow Profits and Market Share in a Time of Transition" (Chicago: DiamondCluster, 2005).

134 B. Grow and R. Berner, "Fresh Pain for the Uninsured: As doctors and hospitals turn to GE, Citi, and smaller rivals to finance patient care, the sick pay much more," Business Week, December 3, 2007.

135 E.S. Fisher et al., "The Implications of Regional Variation in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Health Care," Annals of Internal Medicine, 138 (4) (2003): 273-87; R. Abelson, "In Health Care, Cost Isn't Proof of High Quality," The New York Times, June 14, 2007.

136 McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States."

137 S.R. Collins, "Health Savings Accounts: Why they Won't Cure What Ails U.S. Health Care," Testimony before the U.S. House of Representatives, Committee on Ways and Means, June 28, 2006.

138 J. Gruber, "Covering the Uninsured in the U.S.: NBER Working Paper Series."

139 Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured." (Washington, DC: Families USA, June 2005).

140 Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America." (Washington, DC: National Academy of Sciences, 2003).

141 For a review of the potential for prevention, see: J.M. Lambrew and J.D. Podesta, "Promoting Prevention and Preempting Costs: A New Wellness Trust for the United States" (Washington, DC: Center for American Progress, 2006).

142 C.W. Craner et al., "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program," Journal of the American Pharmaceutical Association, 43 (2) (2003): 173-184.

143 C. Schoen et al., "Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending" (New York: The Commonwealth Fund, 2007).

144 H. Aaron, "Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?" Health Affairs, 26 (6) (2007): 1622-33.

145 M. Chernew et al., "Value-Based Insurance Design," Health Affairs, 26 (2) (2007): w195-w203.

146 P. Krugman, "First, Do More Harm," The New York Times, January 16, 2007.

147 D. Cutler, Your Money or Your Life: Strong Medicine for America's Healthcare System. (New York: Oxford Press, 2004).

148 G. Halvorson, "Commentary – Current MSA Theory: Well Meaning but Futile," Health Services Research, 39 (4, Part II) (2004): 1119-22.

149 M. Gladwell, "The Moral-Hazard Myth: The Bad Idea Behind Our Failed Health-Care System," The New Yorker, August 29, 2005.

150 J. Cohn, "The Danger of Consumer-Driven Health Care: The Crash Course," The New Republic, November 7, 2005.

151 J.M. Lambrew, J.D. Podesta, and T. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," Health Affairs, Web Exclusive, W5-119-132, March 23, 2005.

152 Editorial, "The Health Law is Working," The Boston Globe, February 10, 2008.

ABOUT THE CENTER FOR AMERICAN PROGRESS ACTION FUND

The Center for American Progress Action Fund transforms progressive ideas into policy through rapid response communications, legislative action, grassroots organizing and advocacy, and partnerships with other progressive leaders throughout the country and the world. The Action Fund is also the home of the Progress Report and ThinkProgress.

Center for American Progress Action Fund
1333 H Street, NW, 10th Floor
Washington, DC 20005
Tel: 202.682.1611 • Fax: 202.682.1867
www.americanprogressaction.org