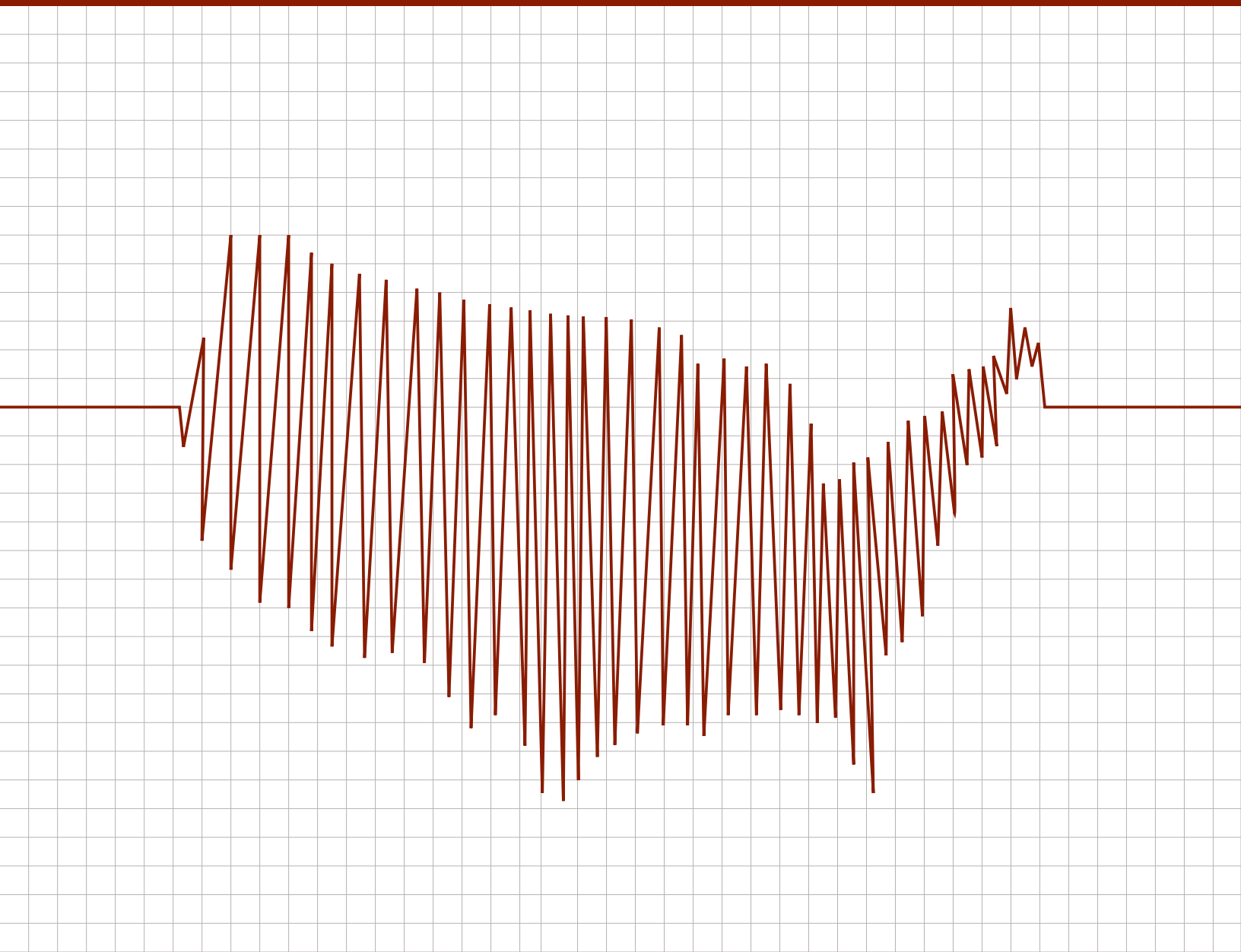


U.S. INDEX OF
Health Ownership

BY JOHN R. GRAHAM

with a foreword by Glenn Hubbard



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Foreword

Who owns your health care? That should not be a difficult question to answer. Surely, in the United States, every American owns his own health care. Unfortunately, this is not the case. Much of the public debate about our health-care “crisis” actually revolves around this very issue. When we look at the choices we make—how to earn a living, what kind of a home to buy for our family, what to do with our spare time—we have more freedom than anyone else in the world.

However, when it comes to health care, we often lack the basic freedom to make our own decisions. Often, in the name of the “public good,” the state inserts itself in ways that Americans would utterly reject in other areas of our lives. Today, almost half of the country’s health-care spending is in the hands of the government, instead of patients themselves. The other half is governed by a bewildering morass of regulations on doctors, insurance companies, and us as patients that nobody can hope to understand. The result: as much as one third-of our health-care spending is wasted. Politicians created this system—the most expensive in the world—and they continue to add more and more layers of government control, usually attempting to fix problems that they created in the first place. They interfere with our freedom to use our own money to make our own choices about the health care we need. Government mandates increase costs and, more important, lower the quality of care. The choice about health care should be in the hands of the patient and his doctor.

With the launch of the *U.S. Index of Health Ownership*, every American can better understand the problem: how politicians, in each of the fifty states, have infringed on their health ownership. In this *Index*, John R. Graham of the Pacific Research Institute has outlined the true magnitude and causes of our lack of health ownership. By articulating our lack of freedom in the area of health care, this *Index* is a valuable addition to the debate about how we as patients can regain control of our own health-care decisions.

R. Glenn Hubbard

Dean and Russell L. Carson Professor of Finance and Economics, Columbia Business School
and former Chairman of the President’s Council of Economic Advisers

Executive Summary

KEY POINTS: From Information to Action

- In the last half century, the level of government control over Americans' health care has increased massively and intrusively.
 - "Health ownership" is the degree to which Americans are still free to engage health resources as they prefer, free of undue state interference.
 - The *U.S. Index of Health Ownership* measures 24 variables in four categories: government health care, private health insurance, medical tort, and provider burden of regulation.
 - Utah, Nebraska, Delaware, North Dakota, and Alabama are the top five, or the states that allow their citizens the highest degree of health ownership. However, even in these states, the level of government control is far greater than necessary.
 - New York, Vermont, New Jersey, North Carolina, and Maine are the bottom five, or the states in which the government has taken the most undue control of health care from its citizens. However, even these states score well on some variables, offering hope for progress if their governments reform.
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WHAT IS "HEALTH OWNERSHIP"?

In a recent survey, Americans named health insurers, managed-care companies, and drug makers as the least trustworthy organizations in the country. Between 40 and 50 percent of the respondents thought these industries should be "more strongly regulated."¹ The industries, however, are grossly overregulated already. The costs of health regulation outweigh the benefits by two to one, according to Professor Christopher J. Conover of Duke University. Specifically, these regulations kill 4,000 more Americans every year than die from lack of health insurance: 22,000 versus 18,000.² Approximately two-thirds of this deadly burden comes from state governments.

The *U.S. Index of Health Ownership* is the first effort to measure the degree to which individuals, be they patients, health professionals, entrepreneurs, or taxpayers, "own" the health care in their states. It quantifies how state laws and regulations affect the liberty of citizens involved in state government health plans (primarily Medicaid), the private health-insurance market, and the provision of medical services. In addition, the *Index* assesses the effect of medical tort on people's freedom to engage health services.

Perhaps the best way to understand this concept is through examples of what health ownership is not:

- A disabled Medicaid beneficiary still able to live in her own home receives living assistance from a nursing aide. State Medicaid bureaucrats decide whom to send into her home, irrespective of whether the Medicaid beneficiary would prefer another nursing aide at the same cost.
- A privately insured patient would like to buy a low-premium health plan coupled with a Health Savings Account (HSA). However, his state's insurance regulations prevent him from doing so.
- A group of surgeons wants to invest in a clinic where they could conduct operations pertinent to their specialty. The local acute-care hospital invokes state power to prevent them from doing so.
- An obstetrician, mindful of research that indicates caesarean sections should be performed only in certain cases, nevertheless frequently performs them in other cases, because not doing so puts him at serious risk of being victimized by a baseless, but costly, medical-malpractice suit.
- A nurse practitioner (NP) wants to establish a clinic to offer patients low-cost treatment. The services she plans to offer are within her scope of competence and professional ethics, but the state requires her to be closely supervised by an MD, thus making the enterprise commercially impractical.

In all these cases, the state has prevented individuals from acting in ways that would further their own interests without harming others. Indeed, in all these cases, allowing these parties to act free of government control would improve health care in the state.

OTHER RESOURCES

The *Index* quantifies issues discussed in *What States Can Do to Reform Health Care: A Free-Market Primer*, a more general way in a collected volume of seven chapters published in 2006 by the Pacific Research Institute (PRI). *What States Can Do to Reform Health Care* is an indispensable companion to the *U.S. Index of Health Ownership*.³

Chapter 1: The Importance of Defining and Measuring Health Ownership

U.S. HEALTH CARE SUFFERS FROM GOVERNMENT CONTROL

“No nation has ever unleashed the forces of market competition . . . on its health-care system.”

JAMES C. ROBINSON, professor, School of Public Health, University of California Berkeley⁴

“The only constant in health care is the anxious anticipation of change that never actually occurs.”

J.D. KLEINKE, health-care entrepreneur⁵

These expert comments reflect truths little understood by ordinary Americans. Indeed, Americans consistently identify the wrong parties as the villains in health care. In a recent survey, respondents named health insurers, managed-care companies, and drug makers as the least trustworthy organizations in the country. Between 40 and 50 percent of the respondents thought these industries should be “more strongly regulated.”⁶

The truth is that these industries are already grossly overregulated. The costs of health regulation outweigh the benefits by two to one. As of 2002, according to Professor Christopher J. Conover of Duke University, the total burden of health regulation in the United States was \$169.1 billion per year, or an average of \$1,500 per family per year. These regulations kill 4,000 more Americans annually than die from lack of health insurance: 22,000 versus 18,000.⁷

Although Professor Conover does not break down his analysis into federal versus state regulations, it is possible to do so. Interpolating from his analysis, about two-thirds of the regulatory burden that he estimates comes from the states (Table 1). Note, especially, that in the realm of health insurance, Professor Conover estimates that federal regulations pertaining to administration and insurance privacy under the Health Insurance Portability and Accountability Act (HIPAA) have a net benefit that the burden of state regulation greatly outweighs. Thus, the state share of these costs is greater than 100 percent.

Type	Total	State	State Share
Regulation of Health Facilities	\$25,074	\$15,409	61%
Regulation of Health Professionals	\$7,133	\$1,857	26%
Regulation of Health Insurance	\$14,377	\$16,175	116%
Food and Drug Administration	\$41,863	Nil	0%
Medical Tort	\$80,646	\$80,646	100%
Total	\$169,093	\$114,086	67%

Source: Author's calculations from Conover⁸

Americans' failure to appreciate these costs is not surprising. Public Choice Theory, developed by James Buchanan and Gordon Tullock over the last half century, informs us that interest groups that benefit from government intrusion will lobby hard for public policies they favor, whereas citizens who prefer to be left alone will not have sufficient incentives either to inform themselves about the harm being done to them or to organize democratic resistance against the government intrusion.⁹ The costs of U.S. health-care regulations, however, are clearly significant.

The concept of "health ownership" is meant to facilitate citizens' understanding of the impact of these burdens on their freedom to engage health resources. The *Index* provides relatively straightforward measurements that will help citizens to identify the role their state governments play in this problem and to demand improvement.

From the examples given in the Executive Summary, it is clear that state governments respond to pressure from interest groups by implementing policies limiting health ownership. To be precise:

- The disabled Medicaid beneficiary's health ownership is reduced because she cannot receive care from the provider she prefers.
- The privately insured patient's health ownership is reduced because he cannot buy a health-insurance plan that serves his needs.
- The physician group's health freedom is reduced because it cannot voluntarily band together to put its members' capital at risk in a venture of their choosing.
- The obstetrician's health freedom is reduced because he cannot exercise his best professional judgment in his patients' interests.
- The nurse practitioner's health freedom is reduced because she cannot earn her living independent of an employment relationship commanded by the state.

PREVIOUS MEASUREMENTS OF FREEDOM AND THEIR RELEVANCE TO HEALTH OWNERSHIP

A number of scholars have measured government intrusion into areas of personal choice and civil society. I have adopted and adapted some of their work, if not by using their techniques then by embracing their principles. In some cases they have contributed to the *Index*.

The first indices produced by scholars advocating individual choice addressed economic freedom. *Economic Freedom of the World* is published by the Fraser Institute in Canada and the Cato Institute in the United States. Begun in the late 1980s, this project has collected data going as far back as 1970 (for some countries) to investigate and measure attributes of economic freedom in the nations of the world. The authors define economic freedom as:

- Personal choice
- Freedom to enter and compete in markets
- Voluntary exchanges controlled by markets
- Protection of persons and their property from aggression by others¹⁰

Clearly, there is a relationship between health ownership and economic freedom. *Economic Freedom of the World* measures 38 data for each country. Over the last decade, a large number of peer-reviewed articles published in scholarly social-scientific literature have used these measurements to explore the positive consequences of economic freedom for human welfare.¹¹ A competing project, the *Index of Economic Freedom*, has been published for 12 years by the Heritage Foundation and the *Wall Street Journal*. This project measures variables within 10 categories, coming to similar conclusions about the beneficial effects of economic freedom to mankind.¹²

Having compared economic freedom across countries, the next step was to compare it across states. In 1999, scholars at Clemson University published the first such study.¹³ The same year, scholars at the Fraser Institute produced a comparison of economic freedom across Canadian provinces, followed by *Economic Freedom of North America*, including both Canadian provinces and American states.¹⁴ The latter employs 10 variables and econometric testing to conclude that an improvement of one percentage point in the all-government index for a state or province increases per-capita GDP by \$5,488.

In 2004, the Clemson scholars teamed up with Dr. Lawrence J. McQuillan of PRI to expand and update the 1999 study. They found 47 variables that affected changes in annual income per capita, discovering that a 10-percent improvement in a state's economic freedom leads, on average, to about a half-percent increase in per-capita income. They also concluded that different levels of economic freedom affected net migration of people among states: people move from economically less free states to those that are more free.¹⁵

Thanks to the serious intellectual firepower invested over many years in understanding economic freedom, these indices stand as impressive statistical and prescriptive achievements. Using regression analysis and other econometric tools, they have succeeded in determining causal relationships. That is, they answer the questions "Does X cause Y, and by how much, and what might explain the rest of Y?"

Indices that analyze other areas of people's freedom and their relationship with human welfare remain at a less developed stage.

Dr. McQuillan and another PRI colleague, Hovannes Abramyan, followed up with an index of tort liability. The study calls upon a body of evidence demonstrating that the status quo of tort litigation in the United States is harmful to human welfare, and that tort reform that limits liability leads to increased labor productivity, more lives saved, greater innovation, and other benefits.¹⁶

The *U.S. Tort Liability Index* weighs equally 39 variables, sorted into five subgroups. Fourteen of the variables are outputs from the tort system such as monetary losses and litigation risks. The remaining 25 variables are inputs (rules and reforms) that shape tort-system outcomes. These inputs include caps on non-economic damages and punitive damages, as well as changes to venue requirements and class-action certification rules.

Why bundle inputs and outputs together in one index? As one of McQuillan and Abramyan's sources notes, even though the feedback loop between inputs and outputs has a significant time lag, the index nevertheless reveals where states stand today in terms of tort outputs and reform-mindedness. States with better tort-liability rankings offer a better legal environment within which to invest for the future and grow, thereby improving their residents' welfare.

Indices like these are easy for laymen to understand; therefore, they are perhaps more important for policy formation than more academic efforts would be. The Heritage Foundation has periodically produced one of the more useful of these, the *Index of Dependency*, which measures the degree to which the federal government has taken over "social obligations and services carried out by community groups, family networks, and even local governments." In other words, the author asks, "has the civil society yielded substantial ground to the federal public sector?"¹⁷ While I have not used the *Index of Dependency* as an input (because it is a national, not a state-based, measurement), I share its author's enthusiasm for the proposition that social services should be provided by governments closer to the people (that is, state and local) rather than by the federal government.

Government control of social services is an important challenge to health ownership. The tenor of our civilization demands that we take care of the health needs of those unable to pay for (or exercise good judgment over) those needs themselves. These fellow citizens necessarily have limited health ownership. We must ask, then, how to transfer resources from those who do not "need" help to those who do. Governments today appear to answer that question in this way: "As far away from their communities as possible, using language and rules impenetrable to members of those communities, and being inflexible in dealing with the nuances and idiosyncrasies of the varied communities encompassing 300 million souls and making up the third-largest country on Earth."

Specifically, programs such as Medicaid and state children's health insurance programs (SCHIP) are delivered by states and their subsidiaries, such as counties. However, the federal government pays more than half the cost of these programs, and decisions—even at the county level—often require approval from the Centers for Medicare & Medicaid Services (CMS) in Baltimore, Maryland, before taking effect. This means that the government of a state is no more accountable to its own residents for how it spends money on health programs than it is to residents of other states, obviously an unsatisfactory situation. Such "accountability" is neither appropriate nor practical.

This has led to out-of-control spending on Medicaid and other health programs, which I have discussed in articles in PRI's monthly *Health Policy Prescriptions* series.¹⁸ Therefore, in the spirit of the *Index of Dependency*, the *Index of Health Ownership* favors states that are relatively more dependent on their own taxpayers to finance health services than on taxpayers of other states.

One interesting measurement that specifically addresses health care is the health misery index, compiled by Professor Rexford E. Santerre of the University of Connecticut. The health misery index comprises two variables: the number of uninsured plus the "excess" rate of price inflation for health

care (that is, the rate by which health-care inflation outpaced general inflation). Using the same method first used by Arthur Okun, who defined a general misery index in 1976 by adding the inflation rate to the unemployment rate, Professor Santerre simply added these two “bads” to conclude that health misery in the United States was much lower in 2003 than it had been circa 1960, and was relatively stable from 1988 into the early 21st century. The index, easy to explain and understand, was published by the *New York Times*, thus exposing millions to its message and allowing the index to have great impact.¹⁹

There are a number of measurements of health-system performance across the states (some of which are included in our *Index*), but most do not directly address the question of individual sovereignty in health care. I have made use of those that do. They include measurements of the regulatory burden of private health insurance, the burden of hospital certificate-of-need regulation, the burden of regulation of health professions, and the burden of medical tort. (These are fully described in Chapter 2, Method and Variables.)

To a degree, measurement of health ownership has been done internationally by at least two free-market research institutes, neither of which attempts the econometric heroics executed by designers of indices of economic freedom.

Canada’s Fraser Institute has published annual editions of a study that compares health systems in developed countries that guarantee so-called “universal access” to health care (thereby excluding the United States).²⁰ Although the study does not use the term “health ownership” or anything like it, it does measure aspects of health-system governance that fit the bill. For example, it asks whether countries force taxpayers to bear the entire cost of an individual’s health care (“first-dollar coverage”), and whether patients are able to direct their dollars, yen, or euros to providers of their choice. It goes on to ask questions such as the following: To what degree does the government enforce a monopoly on the provision of health insurance, and under what circumstances can private insurers, either for-profit or not, compete against the government? Are doctors salaried employees of the state? Do they have a collective fee schedule negotiated with the state? Can they opt out and practice for private payment? Are privately owned hospitals allowed to compete against those run by the government?

Although the authors perform no econometric analysis, and do not “rank” the countries, they conclude that forbidding choice is harmful to patient welfare and does not save money. Thus, they address health ownership, but not in those words.

Many Americans would, I trust, think such questions off the mark in discussing health care in this country, because we understand that private insurers can compete, governments do not run most hospitals, and doctors’ pay is not determined by the state. However, we should not take our current conditions for granted. State governments have a significant effect on the conditions under which these parties operate, analyzing which is the point of this study. In California last year, for example, both houses of the legislature passed a bill that would have abolished all these elements of health

freedom in favor of government monopoly. Fortunately, Governor Arnold Schwarzenegger vetoed this potentially disastrous legislation.²¹

Another international effort to measure factors similar to what I call health ownership has been undertaken by the Health Consumer Powerhouse, a research institute in Brussels. This effort started at the sub-national level. Since 2004, the Health Consumer Powerhouse has published a ranking of “system indicators” for Sweden’s 21 counties.²² Like PRI’s *Tort Liability Index*, the Health Consumer Powerhouse combines inputs and outputs in one measurement, ranking Swedish counties from best to worst performing. Similarly, the Health Consumer Powerhouse now ranks 25 European countries. The *Euro Health Consumer Index 2006* examines 28 indicators of “how the health care consumer is being served by the respective systems.”²³ For each country, each indicator is scored with a 1, 2, or 3, and it is possible for countries to tie.

Because of the nature of European health-care systems, the indicators in these reports do not really reflect “health ownership” as our *Index* understands the concept. The questions basically accept that the patient is on the receiving end of whatever the government thinks he deserves. They focus instead on his right to understand what is going on and, if necessary, to appeal, rather than to take his money and go elsewhere for treatment. These 10 questions include: Are patients’-rights organizations involved in decision making? Is there a patient ombudsman? Does the patient have access to his own medical record? In addition, the European index focuses only on the consumer, not on the freedom of all actors in the health-care sphere to operate with limited interference by the state, which the *Index of Health Ownership* addresses.

Readers may ask whether economic freedom and health ownership necessarily go hand in hand. After all, economic freedom depends on low taxes, among other things, and the *Index* accepts, as a matter of fact, that governments in the United States account for about half of health spending. This spending, of course, comes out of taxpayers’ pockets. Thus, we have implicitly accepted a certain degradation of economic freedom.

I have dealt with this issue before within the context of another comparison of health indicators grounded in the principle of personal freedom and responsibility. This was a study of Canadian provincial pharmaceutical benefit plans, where I had to address the “generosity” of the drug plans (in terms of reimbursing for new, relatively more effective, but often more expensive medicines) versus the plan managers’ responsibility to manage the taxpayers’ money effectively.²⁴ Mindful that more money spent on medicines (newer ones especially) is associated with reduced hospitalization and other health costs, we simply faced these two factors off against each other and found that the amount of taxpayers’ money spent on drug benefits was somewhat less important than how the subsidy was designed.

Within the Canadian context, we found that if a pharmaceutical benefit plan gave first-dollar (or almost first-dollar) coverage, it had great difficulty controlling costs. Therefore, the plan was more

likely to restrict patients' and doctors' choice of medicines. On the other hand, if it functioned more as a catastrophic insurer, costs were easier to predict and more choice in medicines was feasible.²⁵

In a similar vein, the *Index of Health Ownership* has indicators that point in the same direction as economic freedom. Further, operating under the fact of government health programs, the *Index* has other indicators that point in the direction of maximum patient choice within those programs' limits.

Importantly, the *Index* is contrarian—that is, it goes severely against the tendency of modern society to continually demand more government intervention in our health care. There is no shortage of studies claiming that the government needs to do more, rather than less. For example, the United Health Foundation, a charity funded by UnitedHealth Group, one of America's largest for-profit health insurers, publishes *America's Health Rankings* annually. This publication ranks intermediate outcomes such as childhood immunizations and smoking prevalence—fair enough. However, the report also includes government health programs in its rankings as a positive factor, obviously in opposition to the principle of individual health ownership.²⁶

Our *Index* enters a discussion in which champions of freedom in the United States have compared indicators of economic freedom and tort liability. Champions of freedom outside the United States have compared indicators that approach the idea of health ownership to some limited degree but are more relevant to the realities of those countries, which is as it should be. The *Index* also enters an American health-policy environment dominated by calls for unlimited government spending, coordination, standards setting, and general rule making that would restrict freedom of action in health care.

I trust that our *Index* will influence the climate of public opinion against those calls and in favor of more individual health ownership.

Chapter 2: Method and Variables

VARIABLES AND SUPPORTING SCHOLARLY LITERATURE

Table 2 lists the four categories and 24 variables used to construct the *Index*. The observations for each variable for a state are either discrete measurements or continuous standardized frequencies, the same two ranking methods used by my colleagues who previously devised the *Tort Liability Index*.²⁷ If the variable measures discrete observations, the possible number of discernable gradations is listed in brackets beside the variable. The absence of such a number indicates that the variable is continuous—that is, that the states are simply ranked from first to 50th.²⁸ Of the 24 variables, 14 are discrete and 10 continuous.

I. Government Health Care	III. Medical Tort
1. Medicaid Innovation: Waivers—Population 1987–2006 [continuous]	13. Medical-Malpractice Insurance Loss Ratio, 2004 [continuous]
2. Prescription Share of Medicaid Spending, 2004 [continuous]	14. Caps on Damage Awards in Medical-Malpractice Lawsuits, 2006 [31]
3. Medicaid Managed-Care Enrollees' Share of Total Medicaid Population, 2003 [continuous]	15. Medical-Malpractice Attorney-Fee Limitations, 2006 [13]
4. Federal Medicaid Matching Funds Relative to Poverty, Ability to Pay, Cost of Care, 2004 [continuous]	16. Conditions on the Use of Expert Witnesses, 2006 [8]
5. Medicaid Income Eligibility, 2005 [continuous]	17. Pre-Trial Screening or Arbitration, 2006 [11]
6. SCHIP Enrollment Increase, December 2003–December 2004 [continuous]	18. Statute of Limitations, 2006 [33]
II. Private Health Insurance	IV. Provider Burden of Regulation
7. Burden of Regulation, 2006 [12]	19. Share of Hospital Beds Owned by State/Local Government, 2004 [continuous]
8. Burden of Mandates, 2006 [continuous]	20. Burden of Hospital Certificate-of-Need (CON) Regulation, 2006 [32]
9. Percent Uninsured, 2003–2004 [continuous]	21. Corporate Practice of Medicine, 2003 [5]
10. High-Risk Pool, 2006 [12]	22. Telemedicine Licensure, 2003 [8]
11. Individual Premiums, 2006 [5]	23. Nurse-Practitioner Prescribing Autonomy, 2004 [5]
12. Small-Group Premiums, 2006 [5]	24. Nurse-Practitioner–Physician Relationship, 2004 [9]

The four categories into which the variables are grouped are related. For example, if the government provides more health care than necessary, it will deform the private insurance market. If the private insurance market is overregulated, more citizens will be thrown onto government health care.

If providers are overregulated, both beneficiaries of government health plans and privately insured patients in states where those categories operate well will be unable to fully benefit from that aspect of health freedom, because innovative suppliers of health care are unable to compete to serve their preferences. And if the medical tort system is out of control, costs will be too high, frustrating patients and providers even if the other three categories are relatively free. Clearly, the feedback loops comprise wheels within wheels, and the *Index* encourages policy makers to improve all categories of health ownership by using the relatively easily measured levers provided here.

Selecting the variables was challenging. From hundreds, we determined which ones were both important to health freedom and relatively easy to measure. Where appropriate, this *Index* uses and credits the efforts of others. However, as with the *U.S. Tort Liability Index*, to some degree these variables were selected by the states themselves.²⁹ Because states have interfered with their citizens' health ownership, which is the "state of nature," these interventions presented themselves for examination. The *Index* simply collects them.

Scholarly literature supports improving health ownership, as described in our companion volume, *What States Can Do to Reform Health Care: A Free-Market Primer*, published last July.³⁰ Evidence put forward in that book, and in other sources, is cited below for each variable, supporting the variable's inclusion in the measurement of health ownership.

Even more important, these variables provide both a basis for action by state policy makers to improve the level of health ownership for their citizens and a foundation for citizens to demand such action.

I. GOVERNMENT HEALTH CARE

The following variables measure how the state manages its health welfare programs, Medicaid, and the state children's health insurance program (SCHIP). They examine both innovation in such programs and the growth of the programs. The historical capacity of a state to innovate within these programs is likely a leading indicator of its future enthusiasm for recently introduced reform opportunities at the federal level, which Nina Owcharenko of the Heritage Foundation and I have discussed in our companion volume and elsewhere.³¹

1. Medicaid Innovation: Waivers–Population 1987–2006. Medicaid is a joint federal-state program. One reason that it has proved difficult to control the growth of Medicaid is that states pull down matching funds from the federal government when they expand the program. When a state grows a program by one dollar, the federal government throws in at least another dollar. Thus, state governments can buy political capital and government growth via a convenient "two for one" deal.³² Unfortunately, both taxpayers and Medicaid beneficiaries suffer because state politicians' and bureaucrats' overarching goal is to pull federal money into the state without being overly concerned with accountability.

Through a waiver from the U.S. secretary of Health and Human Services, the state basically makes a trade: more freedom to innovate in its Medicaid program in exchange for a cap on the federal matching payments. Thus, the state takes more responsibility for its own Medicaid population. Obviously, this description is an over-simplification. Because this variable is the only one “freshly baked” for the *Index*, I will explain it in more detail.

There are basically three types of waivers. Section 1115 waivers are for research and demonstration projects; the waivers generally last for five years and can be renewed. One example is the Massachusetts MassHealth 1115 waiver, first approved in 1995 and subsequently re-authorized. Put simply, this waiver permits the state to subsidize the purchase of private, employer-sponsored health insurance for the traditional Medicaid population, among others. Section 1915(b) “Managed Care/Freedom of Choice” waivers allow states to enroll some beneficiaries in managed-care programs or carve out delivery systems for specialty care. Section 1915(c) “Home and Community Based Service” waivers are designed to offer flexibility of care in both traditional and non-medical settings, including using family members as caregivers.³³ Obviously, all these waivers increase health ownership, while the fiscal conditions limit taxpayers’ liability.

From 1987 to 2006, states earned 382 of these waivers, including pharmacy waivers and excluding waivers specific to Hurricane Katrina. The *Index* cannot measure the effectiveness of each waiver, and I have little doubt that some were disastrous. Nevertheless, they are an indication of Medicaid innovation valuable to health ownership, and bad waivers can die a painless death.

States are scored according to a three-step process. First, all waivers earned by a state are counted and weighed (linearly) by the year granted. A waiver granted in 2006 is worth more than one granted in 1987. This captures the trend of Medicaid innovation. If a state earned a few Medicaid waivers in the 1990s and then gave up, it scores poorly. If a state continues to innovate through obtaining waivers, it scores well.

This score is then adjusted twice, first for the size of the population. A large state will tend to have more waivers. It likely has a larger Medicaid bureaucracy and more political influence in Washington, D.C., enabling superior navigation of the federal bureaucracy. Also, with more people, it naturally needs more waivers to accommodate local needs. California, for example, has many county-specific waivers, and Delaware does not. This variable should not punish Delaware for having fewer people.

However, a second adjustment is now necessary, since the first has a bias in favor of states with small populations and large geographical size. Alaska thus leaps to the front. Alaska would reasonably have a greater natural need for waivers to satisfy local needs than Delaware or Rhode Island, and this variable should not punish states for being small in geographical size. Thus, it is adjusted for square miles as well as population.

2. Prescription Share of Medicaid Spending, 2004. This variable runs contrary to commonly held notions about the evils of pharmaceutical overuse: states that spend relatively more of their Medicaid budgets on prescriptions score higher. Evidence supports the value of pharmaceutical versus other health spending. As explained in the companion volume to the *Index*, focusing on containing pharmaceutical costs has the effect of “squeezing the balloon,” because spending more on prescription drugs—especially newer, more innovative ones—saves a multiple of those costs in physicians’ offices and hospitals.

Further, state Medicaid plans tend to be more restrictive than private insurers in listing newer prescription drugs for reimbursement, because they do not have to be responsive to competitive forces.³⁴ Accentuating this problem, Medicaid populations have medical characteristics and conditions that make them even more appropriate candidates for newer, more expensive medicines than the general population.³⁵ Although this variable does not directly address whether state Medicaid plans are spending appropriately on newer medicines, a higher share of Medicaid spending invested in pharmaceutical therapies is a good indication.

3. Medicaid Managed-Care Enrollees’ Share of Total Medicaid Population, 2003. This variable measures the share of Medicaid beneficiaries enrolled in Medicaid managed-care programs: the more the better. This is related to variable 1, because waivers are often used to move beneficiaries from traditional, fee-for-service Medicaid to managed-care programs. As with variable 1, variable 3 would be improved by more precise information. I have no doubt that many Medicaid managed-care programs work poorly. Tennessee’s TennCare is a grim example that has led one free-market health-policy analyst to denounce Medicaid managed care *in toto*.³⁶

Managed care is certainly not the ultimate solution to the challenges of Medicaid. Nevertheless, given the legislative and regulatory limits that have historically burdened Medicaid innovation, managed care has been a somewhat useful tool for addressing the necessary trade-off between containing costs and serving Medicaid patients’ health needs. Between 1996 and 2004, the share of Medicaid beneficiaries nationwide enrolled in managed care has increased from 40 to 61 percent.³⁷

Traditional Medicaid, delivered directly by the state, faces an insurmountable problem: the government has no idea what the correct price of a health good or service is. Because of this ignorance, valuable services are increasingly unavailable. Medicaid beneficiaries risk having trouble getting primary care because fewer doctors are accepting Medicaid patients. Between 1996–97 and 2004–05, the number of physicians receiving no Medicaid revenue increased by 13 percent, from 12.9 percent to 14.6 percent, and more than one-fifth of physicians reported that they accepted no new Medicaid patients last year.³⁸ Although Medicaid managed-care plans have limits similar to private managed care, they typically provide better access to care than traditional Medicaid, can negotiate more attractive terms with providers, and are associated with savings for the states, especially with respect to disabled Medicaid beneficiaries.³⁹

Medicaid managed care does not fully avoid the problems of traditional Medicaid. It is not as if beneficiaries have vouchers that they can use to shop around for the managed-care program they prefer. Rather, government bureaucrats usually decide for them.

Unsurprisingly, because there is no monolithic model of Medicaid managed care, studies from various places during different periods show mixed results. Data from the late 1990s (when managed care accounted for a much smaller share of Medicaid) showed conflicting effects of children's enrollment in managed care: more outpatient visits substituting for emergency-room use and hospitalizations, but lower satisfaction for patients and self-reported delays in receiving care.⁴⁰ Other research has shown convincing evidence that Medicaid managed care provides superior outpatient service to hard-to-reach populations, drastically reducing hospitalization, and that children and pregnant women also received better quality care.⁴¹

The literature on Medicaid managed care does not speak with one voice.⁴² Nevertheless, a number of positive examples exist. A state's flexibility in outsourcing part of this welfare program to the private sector bodes well for its willingness to innovate even further, using new tools that the federal government has recently provided, such as Health Opportunity Accounts.⁴³

4. Federal Medicaid Matching Funds Relative to Poverty, Ability to Pay, Cost of Care, 2004.

Another factor limiting states' willingness to reduce health-care welfare dependency is that the federal government matches state payments according to a formula guaranteeing that at least half of a state's Medicaid spending comes from outside its borders. Obviously, this creates an incentive to overspend, because the state can take credit for the entitlement while blaming the taxes on the federal government.⁴⁴

This variable is the first (but not the last) for which I depend entirely on the insight and analysis of others—in this case, John Goodman and colleagues at the National Center for Policy Analysis. They point out that this federal matching formula has a perverse consequence: states with higher incomes are able to spend more own-source revenue on Medicaid than poorer states, and thereby draw down more federal dollars. Goodman and colleagues determined how much more in federal matching funds each state receives than it “deserves” based on the number of poor people it has.⁴⁵

This variable might well be labeled the “freeloader” sub-index. Nevada, North Dakota, and South Dakota get ripped off while Alaska, Vermont, and New Mexico have their hands deeper in all Americans' pockets than they reasonably deserve. This variable is a negative indicator; even if one thinks Medicaid is good for poor people, the states that take too much reduce their residents' health ownership by expanding this welfare program beyond the appropriate demographic limits.

5. **Medicaid Income Eligibility, 2005.** The perverse incentive that the federal matching formula creates has resulted in more and more Americans, at higher income levels, being taken out of the private health-insurance market and roped into this welfare program. From zero just four decades

ago, Medicaid now accounts for one in every six health-care dollars spent in the United States.⁴⁶ Curiously, politicians seem proud of expanding Medicaid, and there is not nearly enough movement in the direction that other welfare programs went a decade ago.

This variable measures the income eligibility for Medicaid in a simple way, by adding the Federal Poverty Line (FPL) cut-offs for various groups as reported by the Kaiser Family Foundation's state-health-facts online database.⁴⁷ The database divides the population into six demographic groups and reports their FPL cut-offs. For example, Alabama takes first place in this ranking, with a raw score of 530 percent, which includes 100 percent for older children, 133 percent for younger children, 133 percent for infants, and so on. Minnesota takes last place, with a sum of income-eligibility cut-offs of 1655 percent. In Minnesota, basically everybody earning less than 275 percent of the FPL is eligible for Medicaid.

6. SCHIP Enrollment Increase, December 2003–December 2004. Perhaps the most appalling element of the unlimited growth of government-run health care is the willingness of its advocates to break up families' health care by capturing more children in these programs instead of creating incentives for Americans to buy health-insurance plans that protect their entire families. As above, this variable comes from the Kaiser Family Foundation's database of state health facts.⁴⁸ States that resisted the urge to expand their children's health-insurance programs rank high. And as many as 13 states actually reduced the number of children delivered unto their government health-care bureaucracies.

II. PRIVATE HEALTH INSURANCE

While the unlimited growth of state health welfare programs carves people out of the private health-insurance market, inappropriate regulation of private health insurance has also caused people to become uninsured, as discussed by J.P. Wieske of the Council for Affordable Health Insurance (CAHI) in our companion volume.⁴⁹ Happily, CAHI has also published a comparison of health-insurance regulations in the various states, from which each of these six variables is derived.⁵⁰ I have made two significant adaptations.

First, CAHI weighs the variables differently, whereas here they are weighed equally. Second, CAHI does not rank the states with the granularity that our *Index* seeks, but divides the states into quintiles. Therefore, I have taken one step "behind" CAHI's index, to the factors that CAHI used to sort the states into quintiles, and have sliced the results into smaller gradations (for four of the six variables). The risk here, of course, is that I have assigned significance to differences among states that CAHI's authors did not consider significant. (Indeed, they warn against doing so.) Nevertheless, this is consistent with the method used throughout our *Index*, and as neither CAHI's nor my effort claims to be a statistical exercise, neither method is obviously superior.

7. Burden of Regulation, 2006. This is derived from CAHI's measurement of six factors that contribute to the state regulatory environment: community rating, group size, the Health Insurance Portability and Accountability Act mechanism, guaranteed issue, rate bands in the individual market, and whether the insurance commissioner is elected. These six factors are important to health ownership for the following reasons:

- Community rating refers to rules that require insurers to charge the same premiums to sick and healthy applicants: a recipe for higher costs and higher numbers of uninsured.
- Group size refers to deviation from the industry standard for the size of a small group: two to 50 employees. When a state goes outside this standard to define “one” as a small group it brings individuals out of the market appropriate to them and creates adverse selection, because the small-group market guarantees issue.
- While federal law requires guaranteed issue for HIPAA-eligible persons, states have significant latitude in meeting this requirement. The best way to motivate health insurers to compete for this otherwise unattractive group is to subsidize a high-risk pool for them. The worst way is to mandate guaranteed issue for all plans for which HIPAA-eligible persons may apply.
- Guaranteed issue in the individual market is a step that only 11 states have taken because it so clearly makes that market uncompetitive.
- Rate bands in the individual market allow insurers to charge a range of premiums to patients according to their health status. The wider the bands, the more insurers are likely to compete.
- An elected insurance commissioner is a politician—likely to implement bad regulations for health insurance in order to gain popularity.

8. Burden of Mandates, 2006. This is simply the number of mandates the state imposes on health plans. Examples are requiring drug and alcohol treatment, blood lead-poisoning treatment, or massage therapy, and including non-custodial children in family coverage. The number of mandates ranges from only 13 in Idaho to 62 in Minnesota. Because they increase the cost of health insurance and force the insured to buy unneeded and unwanted coverage, more mandates means less health ownership. Although it would be more informative to measure the cost of each mandate, this is not possible with more than 1,800 mandates throughout the country.

9. Percent Uninsured, 2003–2004. While the share of the population without health insurance is not solely a result of overregulation and the burden of mandates, it is the case that such infringements on health ownership cause young and healthy persons to decline health insurance that they (rightly) believe is too expensive for their needs. This measurement reinforces the previous two by recognizing causes of uninsurance not captured by those somewhat blunt tools. Of course, a state could improve this figure simply by expanding Medicaid, but then its ranking would suffer in the variables for government health care.

10. High-Risk Pool, 2006. States establish high-risk pools in order to create a safety net for those too sick (or likely to become too sick) to be able to find affordable private health insurance. A good high-risk pool will also reduce the number of people in Medicaid, an important goal of health ownership. The state subsidizes the pool and restricts its premiums. CAHI measured five factors:

- Is the pool closed or open to new entrants? Obviously, an open pool provides a better safety net.
- Are the premiums low enough to cause these otherwise uninsurable persons to buy health insurance (rather than drift into Medicaid)?
- Do the benefits have a maximum value of at least \$1 million, no time limit, and the option of a Health Savings Account (so as to make insurance within the pool look similar to the emerging standard for other private health insurance)?
- Is the waiting period for pre-existing conditions similar to that for private insurance outside the high-risk pool (in order to minimize adverse selection in and outside of the pool)?
- Is the pool subsidized by society at large, or by a tax levied specifically on health insurers? A tax on the latter is inefficient, because it causes a general undersupply of health insurance, whereas a general tax makes the subsidy transparent and allows citizens to decide more easily how much they are willing to pay for this good.

11. Individual Premiums, 2006. Without the tax bias, the individual insurance market would become the destination of first resort, not last, for Americans seeking to buy health insurance. Measuring the cost of regulation in this market across states is difficult. Recently published studies rely on one company's data, and even if an analyst can hold premiums, deductibles, and co-payments constant, he cannot control for differences in what is covered in different states. A recent analysis by Dr. Michael New has estimated the increase in premiums due to four types of regulation: mandated benefits, health-plan liability (for harm done to enrollees under assorted liability theories), requirements for direct access to specialists (instead of referral by a primary-care physician), and due-process laws (which interfere with an insurer's right to contract selectively).⁵¹

Drawing from a small number of sources, the CAHI authors were able to estimate average annual premiums in the individual market, ranging from a low of \$1,885 in California to a high of \$6,048 in New Jersey. Although each state has a precise dollar figure estimated, in this case the *Index* concurs with the CAHI authors' judgment that small differences in premiums may not be "real" given the need to triangulate among different sources (e.g., \$2,295 for Nebraska and \$2,299 for Missouri). Therefore, the *Index* also grades the states by quintiles for this variable, reflecting the effects of government intervention in individual insurance not captured above.

12. Small-Group Premiums, 2006. Although using somewhat different sources, the idea here is exactly the same as for variable 11.

III. MEDICAL TORT

Much of the high cost of American health care is explained by this country's uniquely expensive tort system. In the companion volume to the *Index*, Jim Copland of the Manhattan Institute has discussed the evidence.⁵² Specifically:

- Since 1975, medical-malpractice costs have risen four times faster than consumer price inflation and twice as fast as medical price inflation.
- This has caused “defensive” medicine and shortages of physicians’ services.
- Medical-malpractice tort reform reduces physicians’ insurance costs without negatively affecting patients, and even reduces the number of accidental deaths.
- Medical-malpractice payouts and premiums vary significantly among the states.
- Proven and innovative tort-reform policies are available to help states reduce cost and improve patients’ welfare.

PRI’s Lawrence McQuillan and Hovannes Abramyan have already broken ground on the task of measuring these costs across states with the U.S. *Tort Liability Index*, noted above.⁵³ Six of its 39 variables are also appropriate for use in this index.

13. Medical-Malpractice Insurance Loss Ratio, 2004. For this variable (number 6 in the *Tort Liability Index*), McQuillan and Abramyan divided monetary medical-malpractice losses by the gross state product to enable comparisons among states of different sizes. “Loss” is defined as all current and future payments contingent on a single claim, including both awards and settlements, after final appeal.

14. Caps on Damage Awards in Medical-Malpractice Lawsuits, 2006. This variable (number 18 in the *Tort Liability Index*) uses a number of sources to examine whether a state limits damages or requires a higher negligence standard for medical malpractice. Capping these awards is associated with doctors’ performing less defensive medicine and the lowering of medical costs 5 to 9 percent without significant increases in complications or mortality—a significant increase in health ownership.⁵⁴

15. Medical-Malpractice Attorney-Fee Limitations, 2006. States have a number of options for limiting runaway attorney fees. New York uses a sliding scale, from 30 percent for the first \$250,000 of an award down to 10 percent above \$1.25 million. In Washington state, courts approve each party’s legal fees based on perceived reasonableness. McQuillan and Abramyan use two sources for their data (variable number 23 in their *Tort Liability Index*).

Although it appears offensive to liberty for the state to regulate how much a client pays his lawyer in a private business relationship, this intervention has a positive externality. The number of physicians goes up by more than 3 percent after three years, owing to increases both in the number of doctors entering practice and in those delaying retirement.⁵⁴

16. Conditions on the Use of Expert Witnesses, 2006. This variable (number 24 in the *Tort Liability Index*) uses data from two sources to measure the quality of expert witnesses in medical-malpractice cases. Because judges often lack adequate medical knowledge, they can be misled by expert witnesses whose actual role is to maximize awards.⁵⁶ To ensure that judges and juries hear only accepted professional opinions, states have imposed a number of rules on expert witnesses. In Minnesota, medical-malpractice claimants sign an affidavit stating that they have consulted an expert. In Michigan, expert witnesses must be board certified in a similar specialty to the defendant's and up-to-date in that specialty.

17. Pre-trial Screening or Arbitration, 2006. Pre-trial screening and arbitration are two ways to avoid an unnecessarily costly medical-malpractice court case. The former is a hearing to determine if a case is valid; the latter is an alternative to a trial and is conducted by a disinterested party. Pre-trial screening reduces the number of meritless cases that clog the courts.⁵⁷ Arbitration increases the likelihood of the two parties reaching a mutually agreeable settlement. This variable (number 25 in the *Tort Liability Index*) uses data from two sources to score states on how well they use these two valuable options.

18. Statute of Limitations, 2006. States can implement statutes of limitations for medical malpractice. Indiana, for example, has a two-year limit, and Kentucky has a one-year limit after the act or reasonable discovery, with a five-year maximum limit. Using data from two sources, this variable (number 26 in the *Tort Liability Index*) measures how well states use reasonable statutes of limitations to lower litigation rates and ensure that potential medical malpractice is dealt with while incidents are relatively fresh and the connection between cause and effect can still be clearly traced. These limits increase health ownership by lowering legal costs for physicians.⁵⁸

IV. PROVIDER BURDEN OF REGULATION

Although it is critical that the demand for health care be reformed, it is at least as important that the supply be reformed. There is not much point in having an empowered patient if health entrepreneurs are not free to compete. Thus, our *Index* has identified six variables that measure how free providers of health services are to compete for patients' favor.

19. Share of Hospital Beds Owned by State/Local Government, 2004. The *Index* is agnostic with respect to whether not-for-profit or for-profit hospitals are more effective. I lean heavily toward the dominant economic interpretation that there is little real difference, but I do not view the matter as settled.⁵⁹ Whether not-for-profit hospitals, by far the dominant type in the United States today, should lose their preferential tax treatment is not tackled here.⁶⁰ There is, however, no doubt about the effectiveness of private hospitals, either for- or not-for-profit, versus government-owned hospitals.

The scholarly literature favors private ownership in the clear majority of studies. Because privately owned hospitals depend on patients for revenues, they are more likely to have less “slack,” to outsource non-core services, and otherwise to perform relatively well on indicators not immediately obvious through simple accounting measures, even though these hospitals often have higher costs.⁶¹ Using data from the Kaiser Family Foundation, this variable ranks states according to the proportion of hospital beds owned by state and local government, favoring states with less public ownership.⁶²

20. Burden of Hospital Certificate-of-Need (CON) Regulation, 2006. Even privately owned hospitals, however, can act anti-competitively, primarily through CON regulations. In our companion volume, Roy Cordato of the John Locke Foundation discusses the burden of CON regulation.⁶³ Most states prevent new hospitals from opening by effectively giving incumbent hospitals a veto through CON regulation. The idea is to reduce health spending, but in fact CON regulation leads to higher prices and communities suffering for lack of health services.

Of course, not all states’ CON regulations are equally harmful. The regulations are often very complex: a state might require a CON for only a few activities—for example, renal dialysis—or it might cover the whole gamut of hospital procedures. John Barnes, formerly of the Washington Policy Center, has estimated the cost of different states’ CON requirements using data from the American Health Planning Association, and this variable derives from Barnes’ analysis.⁶⁴

21. Corporate Practice of Medicine, 2003. “Corporate practice of medicine” regulations refer to how doctors are employed. Many states have rules forbidding non-physicians from hiring physicians to practice medicine, and medical associations support such restrictions.⁶⁵ However, there is little evidence that this regulation is socially beneficial. For example, if there is a ban on the corporate practice of medicine, a retailer cannot open a health clinic on its premises and hire physicians to staff it. By not allowing such clinics, states prevent innovation in service delivery, merely for the purpose of fortifying one element of physicians’ professional monopoly power, with the result that Americans waste countless hours waiting for health care in their physicians’ (often inconvenient) offices.⁶⁶

Although organized medicine opposes the “corporate practice of medicine” as an intrusion on doctors’ freedom, this opposition is, in fact, an obstacle to both patients and physicians. Obviously, no physician would accept employment from a non-physician unless he considered it in his best interest to do so. His doing so does not interfere with other physicians’ right to act independently of “corporate practice.” Permitting the corporate practice of medicine would facilitate dramatic entrepreneurship. For example, the expanding number of retail clinics that want to have doctors available, as well as nurse practitioners, might prefer to negotiate salaries with those doctors rather than engage them as independent contractors. Restrictions on the type of organization possible in medicine is likely one factor in explaining why patients still access medical care much as they did four decades ago.⁶⁷

Regulations governing the corporate practice of medicine are complex. The Center to Advance Palliative Care (CPAC) surveyed state regulations concerning the corporate practice of medicine, sorting the states into five categories: those where corporate practice of medicine is clearly forbidden, those where it is likely forbidden, those where the regulations are quite unclear, those where corporate practice of medicine is unlikely to be forbidden, and those where it is definitely acceptable.⁶⁸ Our *Index* uses the CPAC rankings, favoring states with freedom to practice medicine on a corporate model.

22. Telemedicine Licensure, 2003. “Telemedicine” is a similar innovation in service delivery. Instead of seeing a doctor in person, patients simply give him a call. Businesses like TelaDoc, based in Dallas, engage physicians to consult with patients nationwide over the telephone.⁶⁹ Remarkably, some states restrict patients’ and doctors’ freedom to communicate across state lines.

As with the corporate practice of medicine, regulations governing telemedicine are complex. The *Index* derives eight gradations from an analysis produced by the Center for Telemedicine Law. The first three gradations concern whether rules governing telemedicine are imposed via legislation, via regulation, or by other means. The other five concern whether the out-of-state doctor needs to be licensed in the patient’s state—specifically for telemedicine or generally — or whether there is an explicit or implicit special-purpose license for telemedicine. As with all other variables, these eight gradations favor the free practice of telemedicine.

23. Nurse-Practitioner Prescribing Autonomy, 2004. For most patients, the freedom of non-physician health professionals to practice in an environment free of overregulation is surely not at the top of their minds. However, it holds significant implications for the health ownership both of patients and of those professionals. One important way this plays out is through the expansion of “convenience clinics.”

Empowered patients, with consumer-directed health plans, are highly motivated to seek out “value for money” in health services. “Convenience clinics” are expanding across the country in pharmacies, supermarkets, and other retail environments. According to Blue Cross and Blue Shield of Minnesota, which studied data from between June 2004 and May 2005, enrollees in consumer-directed health plans were twice as likely to visit such a clinic as patients in traditional health plans.⁷⁰ Unfortunately, rules restricting nurse practitioners (NPs) inhibit this innovation.

For example, in California, one physician must directly supervise no more than four NPs. Convenience clinics tend to be staffed by NPs, so this type of regulation renders them uneconomical.⁷¹ In our companion volume, Professor Shirley V. Svorny of California State University Northridge has described how this sort of overregulation increases health costs and reduces access to health services.⁷²

The *Index* incorporates two measures of nurse practitioners' scope of practice, both from a standard text that addresses the profession's business and legal guidelines. First, it measures their prescribing authority on five gradations. Most states rank low, legally requiring a physician to prescribe or "collaborate" with the NP. The highest score goes to six states that give NPs explicit authority to prescribe independently.⁷³

24. Nurse-Practitioner-Physician Relationship, 2004. The second variable addresses the issue noted above in the California example. This includes nine gradations, from no physician involvement, to collaboration, to supervision.⁷⁴

Chapter 3: Results

The following pages contain the rankings for all fifty states in the Union. These rankings are not merely descriptive, but prescriptive. It is hoped that the successes of the top-ranked states in each category will provide lessons for their peers across the nation; and it is hoped the bottom-ranked states will seek to raise their standings through the application of judicious legislation, sound practice, and free-market principles.

OVERALL RESULTS

Table 3: U.S. Index of Health Ownership Overall Ranking					
Rank	State	Score	Rank	State	Score
1	Utah	18.57534	26	Minnesota	25.75776
2	Nebraska	20.35108	27	Washington	26.10263
3	Delaware	20.71589	28	Mississippi	26.15903
4	North Dakota	20.93480	29	Illinois	26.43672
5	Alabama	21.09380	30	Wyoming	26.46579
6	Montana	21.71126	31	Alaska	26.48480
7	Michigan	22.52405	32	Missouri	26.75738
8	Iowa	22.68392	33	Ohio	26.82706
9	Kansas	22.86282	34	Texas	26.95647
10	Kentucky	23.00448	35	Tennessee	27.61424
11	Louisiana	23.09635	36	Oklahoma	27.88061
12	Oregon	23.35998	37	South Carolina	28.40789
13	Virginia	23.46524	38	Arkansas	28.44536
14	New Hampshire	23.50299	39	Maryland	28.63254
15	Wisconsin	23.89226	40	Hawaii	28.78329
16	Pennsylvania	24.10130	41	Georgia	29.00770
17	Idaho	24.19050	42	Connecticut	29.32553
18	California	24.61334	43	Rhode Island	29.51462
19	Florida	24.87689	44	Arizona	29.56929
20	Colorado	24.93751	45	Massachusetts	30.29504
21	Indiana	25.06661	46	Maine	30.86344
22	New Mexico	25.34526	47	North Carolina	30.92208
23	Nevada	25.55334	48	New Jersey	30.98699
24	South Dakota	25.64426	49	Vermont	33.09226
25	West Virginia	25.73670	50	New York	36.01283

The Top Five: Utah, Nebraska, Delaware, North Dakota, and Alabama

- **Utah** leads the pack, primarily because of a lightly regulated private insurance market. Also, the state's regulatory environment for providers favors competition, and government health programs run more effectively than in most other states. Utah ranks in the top fifth with respect to its government health-care programs, and (just) in the top half for medical tort.
- **Nebraska** is 2nd, performing very well on regulation of private health insurance, medical tort, and the burden of regulation on providers. It also ranks (just) in the top half for government health-care programs.
- **Delaware** is 3rd, with tightly run government health-care programs and a very good medical tort environment. It also ranks in the top fifth with respect to provider burden of regulation, but is only middling with respect to the regulation of private health insurance.
- **North Dakota** is 4th, primarily because of lightly regulated private health insurance and competitive provider markets. It does somewhat less well limiting its government health-care programs and is middling on medical tort.
- **Alabama** is 5th, because of great performance in limiting its government health-care programs and because of lightly regulated private insurance. With respect to regulating providers, the state scores in the top half, but it does relatively poorly with respect to medical tort.

The Bottom Five: New York, Vermont, New Jersey, North Carolina, and Maine

- **New York**, at the bottom of the list, suffers from government health-care programs that are out of control, a grossly overregulated private-insurance market, and almost completely uncompetitive provider markets. It also lies deep in the lower half of the rankings for provider competition and medical tort. However, it scores well on some variables within these categories.
- **Vermont** is 49th, with the worst medical-tort environment. It also trails the pack in the other three categories, especially the regulation of private health insurance. However, like New York, it scores well on some variables within these categories.
- **New Jersey** is 48th, suffering from uncompetitive provider markets and grossly overregulated private insurance. However, it has a middling performance on the other two categories, and does well on some individual variables.
- **North Carolina** is 47th. With very poor provider competition and overregulated private health insurance, the state is also in the bottom half of the rankings for medical tort and government health care. However, it scores in the top half of the rankings on some individual variables.
- **Maine** is 46th and performs especially poorly in all categories except provider burden of regulation, where it is one of the leaders: an inconsistency that rescues it from the absolute bottom.

GOVERNMENT HEALTH CARE CATEGORY RESULTS

Table 4: Ordinal Ranking of State-Government Health Care					
Rank	State	Score	Rank	State	Score
1	Kentucky	15.25000	26	Wisconsin	24.83333
2	Nevada	16.41667	27	Hawaii	25.33333
3	Delaware	16.82500	28	Washington	25.50000
4	Alabama	16.83333	29	Idaho	26.00000
5	South Dakota	17.50000	30	Indiana	26.16667
6	Colorado	18.16667	30	North Carolina	26.16667
7	Tennessee	18.25000	32	Oregon	26.50000
8	Pennsylvania	18.66667	33	Rhode Island	27.00000
9	West Virginia	18.83333	34	Georgia	28.00000
10	Utah	19.00000	35	Wyoming	28.41667
10	Montana	19.00000	36	Oklahoma	28.50000
10	Florida	19.00000	37	South Carolina	29.16667
13	Virginia	19.50000	38	California	29.41667
14	Maryland	20.66667	39	Vermont	29.50000
15	Iowa	21.00000	40	Massachusetts	29.75000
16	North Dakota	22.50000	41	Missouri	31.66667
16	Connecticut	22.50000	42	Arizona	32.83333
18	Texas	22.58333	43	New Hampshire	33.91667
19	Michigan	22.66667	44	Ohio	34.33333
20	New Jersey	23.16667	45	Maine	35.00000
21	Louisiana	23.33333	46	New York	35.08333
22	Nebraska	23.50000	47	Alaska	36.08333
23	Kansas	23.66667	48	New Mexico	36.75000
24	Mississippi	24.00000	49	Illinois	38.00000
25	Arkansas	24.16667	50	Minnesota	39.66667

The Top Five: Kentucky, Nevada, Delaware, Alabama, and South Dakota

- **Kentucky** leads this category, investing in pharmaceutical spending and enrolling its Medicaid beneficiaries in managed-care plans. It has also exhibited relative restraint in bringing more children into government-run health care.
- **Nevada** ranks 2nd, performing outstandingly on Medicaid managed-care enrollment, not drawing down disproportionate federal funds, and limiting Medicaid income eligibility.
- **Delaware** achieved 3rd place by using waivers to innovate within Medicaid, limiting Medicaid eligibility, and not bellying up to the federal trough.
- **Alabama** comes in 4th, with severely limited Medicaid eligibility and correspondingly low federal matching funds.
- **South Dakota** comes in 5th, performing very well on enrolling Medicaid beneficiaries in managed care and avoiding dependency on federal matching funds.

The Bottom Five: Minnesota, Illinois, New Mexico, Alaska, and New York

- **Minnesota**, in last place, suffers from extremely high Medicaid eligibility, poor innovation through waivers, freeloading on federal taxpayers, and likely inadequate investment in prescription drugs.
- **Illinois**, at 49th, does very poorly with respect to Medicaid innovation through waivers, enrolling beneficiaries in managed care, limiting Medicaid eligibility, and bringing kids into government health care.
- **New Mexico**, at 48th, seriously underinvests in prescription drugs, is much too dependent on federal matching payments, and has overexpanded Medicaid eligibility.
- **Alaska**, at 47th, does terribly by failing to enroll Medicaid beneficiaries in managed care, taking more than its fair share of federal matching funds, and underinvesting in prescriptions for its Medicaid population.
- **New York**, at 46th, is dragged down by its place at the federal trough, but is also deep in the bottom half of the other variables in this category, except SCHIP expansion, which was relatively limited.

PRIVATE HEALTH INSURANCE CATEGORY RESULTS

Table 5: Ordinal Ranking of State Private Health Insurance					
Rank	State	Score	Rank	State	Score
1	Iowa	5.30303	26	Delaware	23.99621
2	Utah	8.04545	27	Hawaii	24.31061
3	Minnesota	10.65152	28	Alaska	24.93561
4	Idaho	11.01894	29	Virginia	25.15909
5	Alabama	13.18561	30	New Hampshire	25.81439
6	Kansas	13.63636	31	Arkansas	26.01894
7	North Dakota	13.87879	32	Arizona	26.74242
8	Kentucky	14.33712	33	Rhode Island	28.70455
9	Nebraska	14.59470	34	Maryland	29.29545
10	Missouri	15.38636	35	West Virginia	30.50758
11	Indiana	15.85985	36	Nevada	30.61742
12	Wisconsin	17.01894	37	Oklahoma	30.67045
13	Michigan	20.41667	38	Connecticut	30.87121
14	Illinois	20.46970	39	Louisiana	31.11364
15	Ohio	20.52652	40	Georgia	31.60985
16	New Mexico	20.90152	41	Tennessee	31.79167
17	South Dakota	21.62879	42	Vermont	31.96591
18	Oregon	21.75000	43	Washington	32.16667
19	Pennsylvania	22.20833	44	Texas	33.35227
20	South Carolina	22.31061	45	North Carolina	33.92803
21	Montana	22.42803	46	Florida	35.34091
22	Mississippi	22.47348	47	Massachusetts	35.84091
23	Wyoming	22.83712	48	Maine	40.00758
24	Colorado	23.62121	49	New Jersey	41.77273
25	California	23.72348	50	New York	44.75758

The Top Five: Iowa, Utah, Minnesota, Idaho, and Alabama

- Iowa, the leader, enjoys extremely low premiums for both individual and small-group markets, has few uninsured, and has a light burden of mandates.
- Utah, 2nd, enjoys a very low burden of regulation, as well as low premiums for both individual and small-group markets.
- Minnesota, 3rd, partly makes up for its government-health-care performance through low premiums and a low percentage of uninsured. Free of undue regulation, the state's insurers nevertheless labor under too many mandates.
- Idaho, 4th, enjoys very low individual premiums and very light mandates, and is relatively free of regulation.
- Alabama, 5th, has a very light burden of both regulation and mandates.

The Bottom Five: New York, New Jersey, Maine, Massachusetts, and Florida

- **New York**, in last place, performs poorly in every area, especially its premiums and its high-risk pool (or lack thereof).
- **New Jersey**, 49th, has almost exactly the same profile as its neighbor.
- **Maine**, 48th, also has very high premiums and fails badly in the high-risk pool variable.
- **Massachusetts**, 47th, suffers from the burden of regulation, high individual premiums, and a weak high-risk pool.
- **Florida**, 46th, has high small-group premiums, a high number of uninsured, and a heavy burden of mandates.

MEDICAL TORT CATEGORY RESULTS

Table 6: Ordinal Ranking of State Medical Tort					
Rank	State	Score	Rank	State	Score
1	Michigan	12.72118	26	Colorado	29.10799
2	Louisiana	15.78333	27	North Dakota	29.17292
3	California	16.66736	28	Mississippi	29.63368
4	Illinois	19.54861	29	North Carolina	29.70938
5	Nebraska	21.15451	30	Ohio	29.74410
6	Delaware	21.32708	31	Wyoming	29.83854
7	Virginia	21.49583	32	Tennessee	29.96389
8	New Hampshire	21.70799	33	Alabama	30.08542
9	Alaska	23.13090	34	Indiana	30.71910
10	Florida	23.33854	35	Montana	31.48472
11	Texas	24.32778	36	Pennsylvania	31.57188
12	Nevada	24.33264	37	Iowa	31.94826
13	Oklahoma	25.24201	38	New York	32.08194
14	South Carolina	25.46215	39	Arkansas	33.18611
15	Kansas	25.96076	40	Kentucky	33.31042
16	Massachusetts	26.16563	41	Arizona	33.59722
17	Washington	26.28090	42	Maine	33.82118
18	West Virginia	26.61111	43	Missouri	34.48576
19	Idaho	26.68056	44	Connecticut	34.61840
20	Minnesota	27.69201	45	New Mexico	35.22951
21	Wisconsin	28.36493	46	Hawaii	36.29826
22	Georgia	28.64028	47	Rhode Island	38.68958
23	Utah	28.73507	48	Maryland	39.08889
24	New Jersey	28.86910	49	South Dakota	39.51076
25	Oregon	29.00938	50	Vermont	44.14792

The Top Five: Michigan, Louisiana, California, Illinois, and Nebraska

- **Michigan** takes first place because of caps on damages, conditions on the use of expert witnesses, and pre-trial screening or arbitration.
- **Louisiana**, 2nd, caps damages, has a good statute of limitations, and does well in all variables in this category except limiting attorneys' fees.
- **California**, 3rd, does well by limiting attorneys' fees and achieving a relatively small loss ratio.
- **Illinois**, 4th, succeeds especially through capping damages and putting conditions on the use of expert witnesses
- **Nebraska**, 5th, caps damages and has a very good medical-malpractice loss ratio, as well as a statute of limitations, but it performs poorly on some of the variables.

The Bottom Five: Vermont, South Dakota, Maryland, Rhode Island, and Hawaii

- **Vermont**, 50th, performs poorly in all variables in this category, with the score for its statute of limitations only slightly less awful than the scores for its other variables.
- **South Dakota**, 49th, performs extremely poorly in the areas of limits on attorneys' fees and conditions on the use of expert witnesses.
- **Maryland**, 48th, suffers from a high loss ratio and poor statute of limitations.
- **Rhode Island**, 47th, does especially poorly on limiting attorneys' fees and capping damages.
- **Hawaii**, 46th, performs worst on imposing conditions on the use of expert witnesses, and lies in the bottom half for all other variables in this category.

PROVIDER BURDEN OF REGULATION CATEGORY RESULTS

Table 7: Ordinal Ranking of State Provider Burden of Regulation					
Rank	State	Score	Rank	State	Score
1	New Mexico	8.50000	26	West Virginia	26.99479
2	New Hampshire	12.57292	27	Oklahoma	27.10995
3	Montana	13.93229	28	Indiana	27.52083
4	Maine	14.62500	29	Texas	27.56250
5	Oregon	16.18056	30	Virginia	27.70602
6	North Dakota	18.18750	31	Illinois	27.72859
7	Utah	18.52083	32	Georgia	27.78067
8	Washington	20.46296	33	Kansas	28.18750
9	Delaware	20.71528	34	Mississippi	28.52894
10	Alaska	21.78935	35	California	28.64583
11	Florida	21.82813	36	Colorado	28.85417
12	Louisiana	22.15509	37	Kentucky	29.12037
12	Nebraska	22.15509	38	Hawaii	29.19097
14	Ohio	22.70428	39	Connecticut	29.31250
15	Rhode Island	23.66435	40	Massachusetts	29.42361
16	South Dakota	23.93750	41	New Jersey	30.13947
17	Pennsylvania	23.95833	42	Arkansas	30.40972
18	Alabama	24.27083	43	Tennessee	30.45139
19	Wyoming	24.77083	44	Nevada	30.84664
20	Minnesota	25.02083	45	New York	32.12847
21	Arizona	25.10417	46	Iowa	32.48438
22	Wisconsin	25.35185	47	Idaho	33.06250
23	Maryland	25.47917	48	North Carolina	33.88426
24	Missouri	25.49074	49	Michigan	34.29167
25	Vermont	26.75521	50	South Carolina	36.69213

The Top Five: New Mexico, New Hampshire, Montana, Maine, and Oregon

- **New Mexico** takes this category because of few restrictions on nurse practitioners' scope of practice and the corporate practice of medicine.
- **New Hampshire**, 2nd, does very well with respect to NPs and a very small share of government-owned hospitals.
- **Montana**, 3rd, is not outstanding in any single variable, but ranks in or very near the top half of all.
- **Maine**, 4th, enjoys an idiosyncratically high showing through giving freedom to NPs and allowing the corporate practice of medicine.
- **Oregon**, 5th, allows NPs a broad scope of practice and lightly regulates hospitals via CON.

The Bottom Five: South Carolina, Michigan, North Carolina, Idaho, and Iowa

- **South Carolina**, in last place, lies well in the bottom half on all the variables except the NP–physician relationship.
- **Michigan**, 49th, although it does very well on medical tort, lands in the bottom half of all the variables in this category except the share of hospitals owned by government.
- **North Carolina**, 48th, languishes well in the bottom half of all variables except the NP–physician relationship.
- **Idaho**, 47th, which did well in the private-health-insurance category, suffers from too many hospital beds under government ownership, overregulation of NPs, and the corporate practice of medicine; however, it scores well on hospital CON regulation.
- **Iowa**, 46th, which does well in other categories, is burdened by overregulation of NPs and the corporate practice of medicine. The state also has too many hospital beds owned by the government.

Chapter 4: Conclusion and Policy Implications

This 360-degree approach to determining a good measurement of health ownership has yielded a number of interesting results. Perhaps the most important is that every state can improve. Even the leader, Utah, scores 18 on a scale where the best possible score is 1. Also, there is no state outstanding in all categories or variables. Each state can learn what it must improve to give its citizens more health ownership.

In an environment where too much health-policy discussion revolves around “covering the uninsured” and “insuring all kids” (by the government), it is the hope of PRI and myself that we will be able to repeat this exercise on a regular basis. That will give concerned citizens a good basis to demand from their politicians market-oriented reforms that will result in more health ownership for them and their children, and freedom from government control of their health choices.

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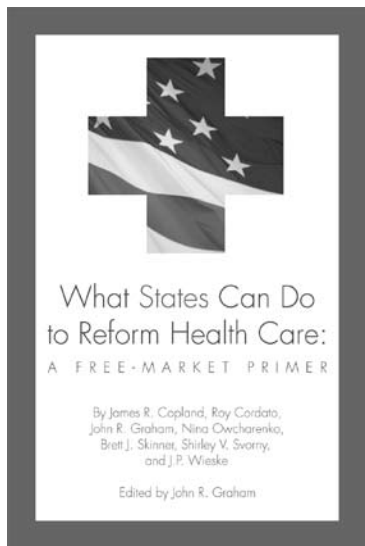
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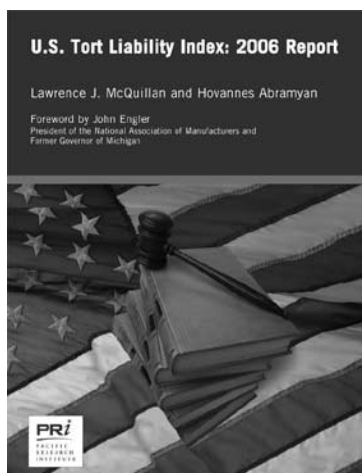
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Newt Gingrich

Former Speaker of the House of Representatives
and founder of the Center for Health Transformation

"In this *Index*, John R. Graham of the Pacific Research Institute has outlined the true magnitude and causes of our lack of health ownership. By articulating our lack of freedom in the area of health care, this *Index* is a valuable addition to the debate about how we as patients can regain control of our own health-care decisions."

R. Glenn Hubbard

Dean and Russell L. Carson Professor of Finance and Economics, Columbia Business School
and former Chairman of the President's Council of Economic Advisers

