



Questionable Cure for a Questionable Crisis:

The Massachusetts Health Plan Takes Shape

by Sally C. Pipes

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Executive Summary



MASSACHUSETTS MADE HISTORY in April, 2006, when it passed a law requiring residents to purchase health insurance or face fines beginning in July 2007. The bi-partisan plan has been hailed as an innovative way to achieve universal health insurance coverage. It places responsibility on the individual to purchase health insurance under threat of fine, asks employers to subsidize insurance or pay a fee, and puts the government in charge of brokering plans that it promises will be affordable. Former Health and Human Services Secretary Tommy Thompson predicts that at least 20 states will soon follow Massachusetts' lead and pass health care legislation with individual mandates.

A close examination of the program calls into question the premises underlying its passage and its ability to deliver on its promise of near universal coverage at affordable cost. And with the election in November 2006 of Democrat Deval Patrick to become Governor of Massachusetts, the ball is really up in the air.

The plan is unlikely to achieve universal coverage. All but three states require drivers to have automobile insurance, yet 14 percent of drivers remain uninsured. Political pressure in Massachusetts will undermine the enforcement

of the mandate. In fact, there is already a strong push to exempt everyone under 300 percent of the poverty level from the mandate because even the new, highly subsidized plans rolled out by the state are unaffordable.

The subsidized plans may be expensive for the insured. They will certainly prove dear to the taxpayer. The governor originally advertised the program at a cost of \$125 million. In a bond filing a few months after passage, the administration revealed that the program would actually cost \$276 million. More instructive,

following the money explains the broad support the plan enjoyed, as the program will, provide \$386 million in rate increases for “hospitals, physicians, and managed care organizations.”

As the program’s cost explodes, tremendous pressure will build to increase taxes on both individuals and the businesses employing them to fund the program.

The voluntary uninsured, those who could afford insurance but choose not to purchase it, do not drive health care costs, spending, or taxpayer subsidies in Massachusetts. The state’s own data show that a mere six percent of the state’s subsidy for the uninsured is devoted to people living in households with incomes greater than twice the federal poverty limit. In fact, to the degree that there is cost shifting, it appears to be from government programs to the private sector. Medicaid pays \$.92 for each \$1 of hospital care its recipients consume. Medicare reimburses \$.95 for each \$1 of care.

The reason that young healthy people don’t purchase health insurance isn’t because they want to free ride on the taxpayer. People don’t purchase it because regulations that proscribe gold-plated benefits and prevent medical underwriting make certain costs far outstrip the expected benefits. The average family plan in Massachusetts costs \$10,126, compared to \$4,424 nationally. The solution to this problem is to deregulate the market, not force people to purchase something they don’t value at artificially high prices.

The legislation’s most promising feature is the health care Connector, a government-created clearinghouse that will allow most individuals employed in Massachusetts to purchase individual health insurance policies with pre-tax dollars. If successfully implemented, this will effectively reduce the cost of insurance for individuals subject to the income tax, prompting some to purchase insurance even in the absence of a mandate.



Introduction



Massachusetts made history in April, 2006, when it passed a law requiring residents to purchase health insurance or face fines beginning in July 2007. Conceived by a Republican governor, passed by a Democratic legislature, and blessed by the state's senior U.S. Senator, Ted Kennedy (D-MA), the plan was hailed as an innovative way to achieve universal health insurance coverage. It places responsibility on the individual to purchase health insurance, asks employers to subsidize insurance or pay a fee, and puts the government in charge of brokering plans that it promises will be affordable. Taxpayers will provide generous subsidies for those with low incomes. Before and after its passage, politicians around the country looked for ways to adopt and adapt the plan for their states. The Massachusetts plan is portrayed as a middle-of-the-road solution. "This is really a landmark for our state because it proves we can get health insurance for all our citizens without raising taxes and without a government takeover," said Governor Mitt Romney, "The old single-payer canard is gone."¹

The proof will be in the plan's implementation in the real world, not its passage and placement onto parchment. A close examination of the legislation calls into question the future success of the program, and the premises underlying it. If the plan is to succeed, insurance carriers will need to bring low-premium plans to market and do so profitably. Given the burdensome nature of health insurance regulation in Massachusetts, and the fact that the legislature failed to offer much relief from expensive coverage mandates, offering low-cost plans will be a challenge. The justifications for the plan's individual mandate — that private health insurance markets are plagued by adverse selection and that well-heeled people unfairly take advantage of free care offered by the

health care system — rest on shifty foundations. And if the plan fails to deliver, having promised all state residents access to health insurance, a single-payer plan may just be the next logical stop for politicians. Elected Democrat Governor Deval Patrick puts Massachusetts closer to that stage.

However, the plan has at least one positive element. The most promising aspect of the legislation is the newly created health care Connector — a government brokerage of private insurance that combines small group and non-group markets — that may provide a model for creating a robust market for long-term, individually-owned health insurance by overcoming a harmful bias in the tax code towards employer-sponsored health care.



The First Few Months



ALTHOUGH THE REFORMS ARE MEANT TO INSURE 95 percent of the state's population by private or public means, the politicians left virtually all the important details of the plan to be determined by regulation. A new agency, the Commonwealth Health Insurance Connector Authority (CHICA), is tasked with setting premiums, determining subsidy levels, and designing special insurance policies for young people by next July. So far, two main enabling objectives have been achieved, but a third has faced difficulty.

First, CHICA has approved plans and premiums from the four providers that currently uninsured residents earning less than 300 percent of the Federal Poverty Level (FPL) must choose from via Commonwealth Care.

Second, CHICA has set the subsidies for these plans in a manner that dictates that residents who earn between 100 percent and 300 percent of the FPL will pay between \$18 and \$106 per month,

according to a sliding scale. Because the full cost of the premiums is a little over \$300, taxpayers will end up paying over half the cost.²

Third, Commonwealth Care has begun enrolling its beneficiaries. However, it has already failed to meet the legally determined start date of October 1. All residents with incomes under 100 percent of the FPL but not in MassHealth (Medicaid) are being automatically enrolled in Commonwealth Care. Eligible residents will have until the middle of February 2007 to choose a private plan of their choice within Commonwealth Care.³

However, Commonwealth Care was also supposed to enroll those with incomes between 100 percent and 300 percent of the FPL at the same time. The agency has delayed this until January 2007, at the earliest, deciding to focus its current efforts on those with very low incomes.⁴ This difficulty foreshadows a plethora of challenges to implementing this complex, ambitious, and risky reform package.

The Individual Mandate's Heritage



FOR THE CASUAL FOLLOWER OF NEWS, the Massachusetts health plan, which will require individuals to purchase health insurance by July 2007, exploded into the news from nowhere. Early press such as a December 4, 2005 column in *Time* by Joe Klein titled “The Republican Who Thinks Big on Health Care,” heralded the approach as a “remarkable plan to bring mandatory universal health care coverage to Massachusetts.”⁵ In fact, a health insurance program based on individual mandates and competing private health insurers has a long lineage.

The conservative Heritage Foundation has long been a proponent of individual health insurance mandates. Located on Capitol Hill, Heritage scholars deal not only in the world of ideas, but also with the day-to-day reality of politics and policymaking. When it comes to health policy, the only acceptable line is to profess a desire for universal health insurance — that is, an

uninsured rate of zero percent. Only two ways exist to achieve this goal. The first is to abolish private insurance, create government insurance, and force people to pay for it through increased taxes. The second is to mandate that individuals purchase private insurance.

Heritage has spent years developing plans for the latter. On paper, the concept is appealing. Heritage bases its model on the Federal Employee Health Benefits Plan (FEHBP), a system in which the employer promises a defined contribution to health insurance and employees are free to elect a plan that fits their budget and desires. (The government, that is taxpayers, pays for 72 percent of the cost of the average plan, regardless of which plan a person chooses. The subsidy is capped at 75 percent of a plan's premium, regardless of how inexpensive it is.) In theory, the government or entity creates a marketplace, provides what are essentially vouchers, and then

individuals decide if it makes sense for them to buy in. Competition, therefore, provides price discipline and product enhancement. In Heritage publications, the base plan is often described as a “basic” or “bare-bones” health plan.⁶

If Heritage has distinguished itself on the right, the New America Foundation is making a name for itself on the Democratic center-left. Founded in 1999 by magazine feature writer, editor, and public intellectual James Fallows, the New America Foundation advocates for a national health insurance mandate. It advocates for “universal coverage in exchange for universal responsibility.”⁷ It’s instructive to examine in light of the Heritage model. Although both call for mandates, one offers a modest regulatory model and the other is heavy handed.

The New America Foundation would model the benefits package on the standard package offered federal employees, already defining ad-

equate as one step above the basic level. Employers would be forced to play or pay, having a choice of either providing an employee an equivalent of the standard federal package or being taxed a portion of their payroll. Individuals would be given the opportunity to purchase insurance through new state-sponsored community insurance pools. Private insurance companies would offer the insurance, but it would have to be guaranteed issue, guaranteed renewable and community-rated, all requirements that drastically increase the cost of insurance. Individuals would be required to contribute a “modest share of a family’s adjusted gross income.”⁸ “Modest” is left undefined. The premiums for guaranteed issue, community-rated policies average \$10,126 in Massachusetts for family coverage, and \$14,403 in New Jersey. Massive new subsidies will be required to keep expenditures “modest” for a person earning \$50,000 a year.⁹

The Dynamics of Political Power

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BEFORE ANYONE SUPPORTS concentrating power in the elected or regulatory bodies, they must consider the dynamics of politics and markets. Free markets create and distribute wealth by concentrating costs and diffusing benefits. Steve Jobs, Bill Gates, and Paul Allen, the founders of Apple Computer and Microsoft, took the personal, emotional, and financial risk to create these great companies. The costs, therefore, were concentrated first on them and later on investors who also bore ownership stake. These individuals have certainly benefited from their creativity, vision, and risk they assumed. But so has society. The bulk of the economic benefits are diffused over society, accumulating in small and large efficiencies. The founders have certainly gained more than any other individual from their creations. Yet the benefits to others, when totaled, dwarf the wealth they have amassed.

Politics reverses this dynamic. When it comes to spending other people's money, policymakers have a strong incentive to concentrate the benefits while diffusing the costs. Consider a public works project that promises to place a bridge across a river in West Virginia. Regardless of the economic merits of the project, the benefits are concentrated in the local town and are extremely noticeable and valued. The costs, assuming federal funding,

are spread out across the nation and don't even constitute a rounding error in the average family's budget. The effects, in the formulation of philosopher and economist Frederick Bastiat, are easily seen by a few, who have a strong incentive to spend time and treasure lobbying for the project. The costs, however, are largely unseen. More important, even when noticed, they aren't large enough for any small group of people to make fighting the project worthwhile.

The law of concentrated benefits and diffuse costs applies to health policy as well and should make anyone extremely skeptical that true costs will be controlled by providing benefits packages that are less generous than those already in existence. Consider a health plan that doesn't cover chiropractic service, acupuncture, in-vitro fertilization, or alcohol and drug treatment. Many Americans might prefer such a policy to one that constrains such coverage and the charges that accompany them. Left free to choose, they would purchase a less-expensive policy and be happy to spend the residual money on other goods and services, perhaps even saving it in a retirement or college funding account. Although the savings might only be a few dollars a month, nickels and dimes add up to quarters and dollars. Even \$50 a month devoted not to insurance but to long-term savings, invested in a balanced stock

and bond mutual fund earning eight percent and left to compound over 30 years would be worth roughly \$75,000.

The drug and alcohol rehabilitation industry, chiropractors, and acupuncturists, however, feel different. For them, the financial rewards of basic insurance covering their services are significant. For marginal providers, it might even be the breaking point between survival and finding another profession. These providers have an economic imperative to hire lobbyists and spend time and money convincing policymakers, as opposed to patients, that their services must be included in any benefit package. This dynamic explains why mandates on insurance policies have exploded. “By the late 1960s, state legislatures had passed only a handful of mandated benefits,” according to the Council for Affordable Health Insurance. “Today, the Council for Affordable Health Insurance has identified more than 1,800 mandated benefits and providers.”¹⁰ This increase has occurred even as the number of uninsured has increased and cost is the number one reason why people fail to purchase insurance on their own.

This brings us back to the real world challenge of expecting politicians and bureaucrats to offer citizens the same choices that they grant to themselves, by mandating health coverage for us

based on the options offered to federal employees via the Federal Employee Health Benefits Plan (FEHBP). In the Heritage literature, the FEHBP is usually described as including bare-bones catastrophic insurance that, if available, would be an affordable way for individuals and families to transfer the financial risks of catastrophic health events to a third party. This is not likely to occur in practice. Provider groups will lobby for inclusion of every feature, making compelling cases to legislators and regulators, often with pictures and tear-inducing human stories, as to why their specialty simply must be covered and how it can be accomplished for only a few pennies a day. The pressure is all one sided and since policymakers are never spending their own money, they will oblige and pass the bill along to individuals and families. Put a mandate with teeth in place, and Americans will be forced to purchase insurance they don't want and, in many cases, don't need — or pay fines.

True costs simply can't be controlled under a system in which benefits from additional spending are highly concentrated in a producer group and the costs are either dispersed among millions of people or, even more important, the people making the decision on whether to include the costs are not ultimately the people who bear them.

What the Governor Promised, What the Legislature Delivered



IN 2004, Republican Governor Mitt Romney, widely believed to have presidential aspirations, made health care reform a priority. Massachusetts had secured a waiver from the federal government for extra Medicaid money and federal regulators were threatening to cut off the money unless the state put a plan in place to reduce the number of uninsured. Massachusetts saddles its individual insurance market with regulations such as modified community rating, which means insurers are forced to charge the sick and healthy the same prices. It's the second most expensive state for private insurance, with an average cost for individual coverage at \$5,257 and family coverage at \$10,126. (By contrast, the national average is \$2,268 for individuals and \$4,424 for families).¹¹ In addition, state regulations require that all policies cover alcohol treatment, in-vitro fertilization, and full mental health parity.¹²

One approach would have been to boldly call for the deregulation of the individual insurance market. That, however, would have upset powerful interests whose revenue sources and profits depend on their services being covered. The Governor, did, in fact, call for deregulation, at least in part. He proposed allowing basic plans,

the bare bones kind often explained in the policy literature. "Insurers tell us that they can develop plans costing less than half of today's standard rate of \$500 for an individual," wrote Romney, "These plans still provide primary, preventative, specialty, and catastrophic care. The costs would be lower with higher deductibles and more restrictions."¹³

He also proposed an individual mandate system under which residents of the Bay State would be required to show proof of insurance or post a bond to cover the potential costs of "free care," should they need it.

The bottom line is that it was to be a program of shared responsibility. Individuals would be forced to purchase insurance, but the government would deregulate the market and therefore make the coverage more affordable. The coverage would be available pre-tax, which leveled the playing field between employer-sponsored and individually-owned insurance. And, recognizing that all costs are ultimately borne by individuals anyway, there would be no new taxes or employer mandates. "It will not be a government mandated universal coverage 'pay or play' scheme nor a single payer system," Romney explained in the *Boston Globe*. "It will not require new taxes."¹⁴

What Massachusetts Got



IF THE PROMISE OF UNIVERSAL HEALTH CARE with no new taxes and a rollback in mandates seemed too good to be true, it was. The Governor started his legislative agenda with a tax cut and affordable health plans that come close to what real health insurance would resemble. By the time he signed the bill, he'd given up on the tax cut. The bill he signed included tax increases, and largely left the onerous health insurance regulatory regime in place. It created a new quasi-government bureaucracy with the ability to raise its own budget, the health care Connector. It actually increased the benefits in the already lavish Medicaid program to include dental, vision, and chiropractic.¹⁵ It increased the income people could earn and still be eligible for government-sponsored insurance under the State Children's Health Insurance Program (SCHIP) from 200 percent to 300 percent of the FPL.¹⁶ It included a new mandate on insurance companies to cover dependents until 26 or two years after they became independent of their parents.¹⁷ Provider groups, powerful in Massachusetts, benefited as well. The final bill included \$90 million a year in increased reimbursements through Medicaid payments to hospitals and physicians.¹⁸

The idea of a health care clearinghouse — the health Connector in Massachusetts — where individuals and small groups can purchase individual and small group policies is intriguing. The bill's most promising innovation lies in this agency. Markets have long thrived under centralized spaces, from bazaars to centralized stock exchanges. Yet there's nothing magic about the space, it's the terms under which trade operates that prove essential. Unfortunately, while provided with the power to raise its budget and provide a seal of approval for health plans, people will be able to purchase only state-approved policies in the New Connector. After the passage of the bill, Democratic leaders highlighted the fact that no insurance mandates were repealed and that modified community rating was left unaltered. "All current mandated benefits are protected," states the bill's conference report.

The two concessions Democrats appeared to have made are allowing state income tax deductions for the deposits into Health Savings Accounts (HSAs) that accompany HMOs that offer high deductible plans and allowing a new insurance policy with a slightly less generous benefits package for people ages 19 to 26. The details of this package will emerge from the

state's insurance department, but the bullet points in the governor's presentations are not promising. The deductibles range from \$250 to \$1,000 and co-pays top out at \$40, not really "insurance" at all.¹⁹

The plan also creates an entire new mechanism for subsidizing private insurance for people of limited means. The new regime promises to fine any resident of Massachusetts who can't prove on his or her tax return that he is covered by insurance. What is mandatory must be subsidized, and, therefore, taxpayers will soon be paying for this insurance. Again, it is not a stripped down basic program but a Cadillac with all the extras. The standard small group plan covers all existing state mandated benefits, offers open access physician network, requires no deductible, and caps co-payments at \$20 a visit.²⁰

Massachusetts residents with low incomes will be able to purchase a "Commonwealth Care" plan through the Connector. It appears to be the basic plan without any deductibles and subsidized premiums ranging from nothing for a person with earnings less than the FPL to 5.7 percent of income for an individual at 300 percent of the FPL.²¹

The governor originally explicitly rejected the "pay or play" plan. Yet the bill he signed

appears to hand the bill to business. Businesses in Massachusetts that don't offer health insurance to employees will be fined up to \$295 a person, a number that will most likely increase in the future. The bill also contains a free rider surcharge that effectively puts every Massachusetts business in the group benefits business. Effective July 2007, any business that fails to offer a group health plan or a Section 125 benefit plan to allow employees to purchase insurance through the Connector on a pre-tax basis, will be liable for the entire cost of its employees' health care that surpasses \$50,000 annually. This is an aggregate, not an individual number. Therefore, 50 employees spending \$1,500 each would place a \$25,000 tax on the business. Failure to comply will result in fines up to \$5,000 a week at 18 percent interest.²² There will be plenty of expenses incurred tracking and enforcing this provision.

Then there's the individual mandate. Premised on the idea that those without health insurance are shifting costs onto society, the bill requires that all residents of Massachusetts purchase insurance either through an employer or through the newly established Connector. The bill does attempt to ease the process, by providing a one-stop shop and by mandating

that employers offer employees cafeteria plans. Yet, aside from young adults under age 27, there is no relief from the insurance mandates and regulations that make insurance so expensive in Massachusetts. Enforcing the individual mandate will prove intrusive and expensive. Starting in July 2007, people will be required to include their health insurance policy number on their state tax return. Insurance carriers, in turn, are required to send the state lists of enrollees on a monthly basis. In the first year, failure to comply will result in the loss of one's personal tax exemption. In subsequent years, if a person is without health insurance for more than two months, he will be assessed a fine of half of the premium for every month he went bare.

It is hard to imagine how this program will reduce total spending in the system. So far, it has increased benefits to those who pay nothing for health insurance, increased payments to providers of health care, and provided a near free plan to low income residents who will pay only pennies on the dollars for care they consume. Private employers are faced with either providing a health plan, or paying the government \$295 a year. There's always a bit of fantasy surrounding politics, but, as health economist Arnold Kling noted in

The Wall Street Journal, the solution appears to be "abolish the laws of arithmetic." "The question is this," asks Kling, "What insurance company will provide coverage with \$0 deductible, at an annual premium of \$295, for someone whose health care costs \$6,000 a year?"²³ The answer, of course, is the taxpayer.

The plan is unlikely to achieve universal coverage. All but three states require drivers to have automobile insurance, yet 14 percent of drivers remain uninsured. Political pressure in Massachusetts will undermine the enforcement of the mandate. In fact, there is already a strong push to exempt everyone under 300 percent of the poverty level from the mandate because even the new, highly subsidized plans rolled out by the state are unaffordable.

The subsidized plans may be expensive for the insured. They will certainly prove dear to the taxpayer. The governor originally advertised the program at a cost of \$125 million. In a bond filing a few months after passage, the administration revealed that the program would actually cost \$276 million. More instructive, following the money explains the broad support the plan enjoyed, as the program will, provide \$386 million in rate increases for "hospitals, physicians, and managed care organizations."

Can Private Health Insurance Work?



HEALTH EXPERTS, unusually those who favor a universal government insurance program, have long claimed that free markets cannot provide health insurance due to a problem known as adverse selection. Adverse selection means that parties entering into risk — transferring agreements have different levels of information and will use it to exploit the system. People who expect to use the health care system will seek insurance, while those who are healthy and expect to remain healthy won't. Insurance carriers will be unable to adequately screen applicants, offering rates that are too low for sick people and, in turn, charging healthy individuals too much. Healthy people know they are getting a poor bargain and drop insurance. Less healthy people cling to their coverage. As the pool of insured gets sicker, prices must increase to cover the cost of care provided, and this price increase, in turn, causes the healthy to drop their coverage, as paying for insurance they don't expect to use no longer seems to be a good value. This is known as the death spiral and, as the story is told, private insurance markets fail.

Although the adverse selection story holds up well in theory, it fails in practice. Private carriers actually prove quite efficient in assessing and pricing risk, and risks often prove to be pooled. Health economists Mark Pauly and Bradley Herring undertook an extensive study on the individual and group insurance markets. They found that less healthy people with individual insurance whose risk was twice as high as a healthy person paid only 20 to 40 percent more than the healthy person.²⁴ According to Pauly, “[W]hile high risks do pay higher premiums than low risks, the increase in premium with risk is much less than proportional to the risk increase.”²⁵ Further, data from the companies offering individual insurance show that, across all ages, 88 percent of people who apply for individual insurance are accepted.²⁶

A popular conception of adverse selection that Governor Romney cited repeatedly in materials promoting the individual mandate relies on a misunderstanding of risk transfer and insurance pools. It is claimed that young and healthy people, by refusing to purchase insurance, increase the

costs of older people as they do not have these dollars in the pool to subsidize the people more likely to need care. This is the social insurance view of insurance markets, analogous to our Social Security system in which non-retirees pay taxes to support those who are no longer working. This is not what private insurance accomplishes. Private insurance does not transfer known risks from individuals to institutions or collections of individuals. Rather, it transfers unexpected risks. If we consider other popular forms of insurance, this will become clear.

In health insurance, more mature people pay more as do people with existing health conditions, since their expected use is higher. In automobile insurance, young drivers, and young male drivers pay more than mature drivers, precisely because their expected use of the insurance is higher. When people become elderly, rates may again climb. Those with accidents will pay more than those with clean driving records. If a mature driver took herself out of the pool, it would have no effect on the rates of a teenager. Insurance carriers are pricing risk at each person's expected

usage of the risk transfer service. People must always pay their own way.

The same is true for life and disability insurance. Prices for life insurance are finely graded for a person's age, family health history, and individual health status, including a full lab work-up on bodily fluids. Young people who purchase life insurance don't subsidize the premiums of older people. And healthy people don't subsidize the premiums of those who have marginal health. Each person is priced on his expected usage. In disability insurance, premiums are determined by age, health, and occupation. Again, people who work in occupations more likely to incur a disability will generally pay more per \$1 of benefit. White collar workers will pay less. They do not subsidize each other.

Life, disability, and auto insurance are examples of pure insurance markets. The only objective is for a person for whom the consequences of an unlikely event would be financially catastrophic to transfer the risk to a third party who is able to pool the risk

in exchange for a series of predictable and affordable payments. The transfer must be priced commensurate to the risk or the market would fail. This failure, however, wouldn't be caused by adverse selection. For example, a 25-year old woman in excellent health who has never smoked can currently secure 20 years of term life insurance that would pay \$1 million tax free to her family upon her untimely death for \$380 a year. If she were in average health and a smoker, she would pay \$1,410 a year for the same policy.²⁷ A 50-year old woman in excellent health would have to pay \$1,360 for the same coverage. If she were in average health and a smoker, the rate would jump to \$6,970 a year.²⁸ If the 20-year old was forced to pay the price of the 50-year old, she'd balk, or make other arrangements. This wouldn't be adverse selection. It would be market failure caused by regulation.

So when politicians claim that the young and healthy are increasing costs in Massachusetts by not purchasing insurance, more analysis is needed before this can be accepted. It may be that the young and healthy are refusing to be

taxed by the state through higher than necessary insurance rates to subsidize those whose rates are kept artificially low by regulation.

Policies that force young and healthy people to purchase insurance are essentially a means to tax them in order to subsidize those who are older and less healthy. In the absence of price regulation and government mandated benefits on insurance policies, companies would design, price, and market plans that young and healthy people would find attractive. These plans would most likely combine the qualities of term-life insurance with Roth IRAs. They would offer large coverage for catastrophic losses, nothing for routine care, and the ability to save money on a tax advantaged basis for future care.

What travels under the heading of "health insurance" in the United States, is not really insurance at all, but prepaid medicine and, more important, a source of steady revenue for health care providers. (Note that the Romney health care bill, in addition to imposing new fees on businesses, included expanded coverage for Medicaid recipients and increased payments to

hospitals and physicians, both powerful lobbies.) Insurance exists to transfer pure risks that are unlikely to occur in any given year to any given person and for which the consequences of the occurrence would be catastrophic.

Research on the individual health insurance market is instructive. “The great majority of people who are high risk today were not sicker than average at all times in their lives,” notes health economist Mark V. Pauly. He continues, “Most medical expenses for people under 65 are not related to chronic conditions; they come from a ‘bolt-from-the-blue’ event of an accident, stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance. This is precisely the kind of low probability, high cost event for which insurance works extremely well as a device for substituting a smaller certain payment for an unexpected rare but large payment.”²⁹

Being diagnosed with cancer at a young age is an insurable event. Needing an annual check up is not. Landing in the hospital after a car accident is an insurable event. The pregnancy of

a 26-year old married woman is not. Requiring a pharmaceutical product that costs \$2,000 a month for a rare condition is an insurable event. Needing aspirin for a headache, pills for routine allergies, or to enhance one’s romantic life are not insurable events. Needing large quantities of health care at a young age is an insurable event. Needing large quantities of health care at elderly ages is an expected event, not an insurable event.

Again, life insurance is instructive. Traditional life insurance solved the problem: How is it that people, whom we know will have a 100 percent chance of dying at some point, can have life insurance that pays tax-free money when death occurs? The solution was a bundled product comprising two parts: pure insurance while the person is young and the risk of death is low and a cash savings fund, accumulating tax free, that will build up to large quantities and replace the insurance as the person ages. By the time a person reaches the age of expected mortality, a traditional life insurance policy will return mostly tax-free savings and growth to cover the expected loss. Should a person die young, the policy will pay insurance, again tax-free.

Free Riders or Forced Payers?



MUCH IS MADE OF THE CLAIM that those who lack health insurance foist costs onto society, as people without insurance, studies show, tend to wait longer to receive care and secure that care in the more expensive settings of hospital emergency rooms. When analysts sit down to crunch the numbers, they find that expenditures on health care would be reduced and more care received if people had insurance and received care in the less expensive settings of physician offices and clinics. From here, it is extrapolated that the uninsured transfer costs onto society and, in particular, the insured who must pay higher rates to cover the cost of care received. It is, therefore, seen as an irresponsible shirking of civic duties for people not to purchase health insurance.

The analysis is usually incomplete, however, either because all factors are not considered or because sufficient data are not provided or available. In Massachusetts, for example, a government study found that a higher proportion of Medicaid recipients than the uninsured used emergency rooms for health care that was either better suited for a less intense setting or could have been prevented by routine care.³⁰ Nearly a quarter of Massachusetts' uninsured are already

eligible for government insurance but simply don't sign up.³¹ If these latter individuals, all low income, are among the "uninsured" patients using emergency services in place of lower cost centers of care, then the solution is to give them the incentives to seek the right care at the right time at the right place, which is very difficult to achieve if taxpayers are funding it. The Massachusetts plan is unlikely to even remotely achieve it, because if these residents sign up for subsidized plans via the Connector, those plans are forbidden from using prices to motivate the right choice of care.

Politicians also assert that the largest group of uninsured are young healthy males, some with significant incomes, and conclude that if these individuals were forced to purchase insurance and maintain continuous coverage, total expenditures would be lower. "Our assumption was that [uninsured with incomes greater than 300 percent of the FPL] would be mostly single mothers who just did not have the wherewithal to get insurance," Eric Fehrstrom, Governor Romney's communications director told *The New York Times*. "It turned out it was mostly young males. In some cases they are making very attractive salaries. These are people who just

don't imagine themselves needing care, but, of course, when they break a leg when they're out bungee jumping they go to the hospital and we end up paying for their care anyway."³²

Yet an examination of the people who account for uncompensated care in Massachusetts undermines the assertion that free-riding young affluent males are the culprits. In Massachusetts, young adults ages 19 to 24 only account for 14 percent of the funds dispersed from the state's uncompensated care pool.³³ Only 6 percent of expenditures to cover health care services provided to individuals living in families with reported incomes greater than 200 percent of the FPL, or \$19,600. Seventy-one percent of the distributions were for individuals living in families with per person income of under \$12,728. Forty-two percent of care went to individuals reporting no income.³⁴

Examining the dominant services the pool pays for is instructive as well. Nearly one in five dollars spent by the uncompensated pool pays for charges "with a primary diagnosis of mental health or alcohol/drug use related mental disorders."³⁵ A chemically dependent person with mental illness is not likely to respond to the state's demand that he purchase

private insurance or lose a tax refund. This population, in fact, is the audience for which the uncompensated care pool is designed.

The cost shifting argument is incomplete as well. Perhaps some of the uninsured shift costs onto the insured by receiving charity care. But those with government insurance, Medicaid and Medicare, shift costs on to the privately insured by paying below average reimbursement rates to physicians and hospitals. Medicare pays hospitals \$.95 for each \$1 of care. Medicaid pays \$.92. These two programs pay for more than half of hospital care. Private payers make up the difference.³⁶ Still, the preferred solution for many is to put as many people as possible on government insurance.

The problem must be put in perspective. Uncompensated care for the uninsured in the entire United States appears to be \$35 billion, or less than three pennies for each dollar that Americans spend on health care.³⁷ In Massachusetts, the best estimate places total costs for uncompensated care at \$1.1 billion in 2004.³⁸ Total health spending in the state was \$45.3 billion.³⁹ So, uncompensated care accounts for roughly 2.4 percent of health spending in Massachusetts. Put in perspective,

it's in line with what the average retail store loses to shoplifting and employee theft, which totaled \$29 billion nationwide in 2000.⁴⁰ No systems are leak proof.

The tax code and its subsidies must also be considered. On an individual level, the uninsured pay more income tax than they would if they purchased insurance through their employers. This is simply the flip side of recognizing that those with employer-sponsored health insurance — 60 percent of the population — pay less in taxes as a result of purchasing health insurance. In aggregate, that's an estimated \$189 billion, or \$1,482 for the average household in 2004.⁴¹ If every uninsured individual secured insurance at

average rates, the savings in uncompensated care would be offset in decreased tax revenue.

There is also the issue of tax subsidies to providers. Many hospitals and clinics are non-profit, even though they operate like a business. The reason they enjoy non-profit status is because they are obligated to provide charity care. Experts are currently debating whether non-profit hospitals are adequately discharging their duties and if, in fact, these institutions even provide more free care than their for-profit counterparts. Yet it remains true that many hospitals are already compensated for charity care, both through the tax code and through direct subsidies from federal and state governments.

The Automobile Analogy: Are Mandates Fair? Can They Work?



INDIVIDUAL MANDATES FOR HEALTH INSURANCE are often likened to mandates for car insurance, a product that all but three states (Tennessee, New Hampshire, and Wisconsin) require automobile owners to purchase. “Just as drivers are required to have insurance,” write The New America Foundation’s Michael Calabrese and Laurie Rubiner, “the responsibility to avoid imposing the burden of uncompensated health care costs on society must be elevated from a voluntary to a mandatory duty of citizenship.”⁴² Governor Romney called his system a personal responsibility system. “We insist that everybody who drives a car has insurance,” says Romney. “And cars are a lot less expensive to fix than people.”⁴³ Interestingly, Massachusetts was the first state to require the purchase of automobile insurance, doing so in 1927. The analogy is not appropriate, however, when examined closely. And where it fits, experience shows that politicians shouldn’t expect it to bring about the desired results.

Driving a car is an activity that people can avoid in numerous ways, including relying on highly subsidized public transportation. People cannot avoid the health insurance mandate,

except by moving to a freer state. For cars, the required coverage is minimal, the most common being \$50,000 per accident.⁴⁴ This is far below what a prudent person who had assets to protect would purchase. As the Massachusetts case shows, due to the politics of health care, it will be extremely difficult, if not impossible, for politicians to permit companies to offer “bare bones” plans. In addition, because mandated auto coverage is low, prudent people still pay extra for car insurance that protects them from uninsured and underinsured motorists. That is, individuals buy extra, non-mandatory car insurance to protect them from accidents involving other drivers. Why? Universal mandates don’t work. “Laws in most states have proven ineffective in reducing the number of drivers who are uninsured,” writes the Insurance Information Institute, an industry trade association that tracks these issues closely.⁴⁵ On average, 14 percent of drivers are still uninsured in states that require car insurance. The percent of uninsured in New Hampshire, which doesn’t force its residents to purchase auto insurance, is lower than many states that require it.⁴⁶

Policymakers also appear to be more reasonable when it comes to mandating the

benefits of auto insurance policies, perhaps because there are fewer powerful auto body shop lobbies than health care providers. Two states with high premiums, California and New Jersey, have developed low cost, low benefit policies for low income people with inexpensive cars and few other assets. In New Jersey, one policy covers \$15,000 in personal injury protection, \$250,000 in medical benefits, and \$5,000 in property damage. Another, called the Dollar-A-Day policy, offers coverage for medical care and death, but not liability. In California, low cost policies are offered in selected urban areas. The cars covered have to be valued under \$12,000 and the coverage tops out at \$20,000 in liability. While the premiums are capped for the drivers in the \$300 to \$350 range, the law recognizes that the true costs are not. The costs of the program are shifted to the insurance industry under a “fair share” mandate, which results in drivers of more expensive cars paying above-market premiums.⁴⁷

These stripped down and subsidized policies are analogous to what the Heritage model calls for in theory. Note that in the automobile market, such policies haven’t produced increased rates of

coverage and they do little to reduce the total costs of accidents. They haven’t stopped the shifting of costs. In health insurance terms, these policies would be hospital only coverage. This is certainly not what Massachusetts policymakers or the New America Foundation have in mind for health insurance mandates.

Massachusetts is not the first state to require health insurance. In 1974 Hawaii decided to “solve” its uninsured problem by mandating that employers provide health insurance, paying half the cost of a plan. Most of the uninsured are employed, or at least in and out of the labor market, and, policymakers and thinkers often reason, that if we can force all employers to provide health care, it will make significant inroads into the problem of the uninsured. In 1974, two percent of Hawaiians were uninsured. Today, after 22 years of mandatory insurance, that number stands at 10 percent.⁴⁸ Employers seek to avoid the mandate by hiring part time workers, as only people working more than 20 hours a week fall under the law. Government mandates don’t work. Smart people find ways around spending money on things they do not value enough to purchase voluntarily.

Problem with Mandates:
What's Mandatory Must be Fair, Affordable,
Highly Regulated, and Subsidized



MANDATING THAT INDIVIDUALS PURCHASE INSURANCE for their own good and the benefit of society is seductive. It appears simple: Offer basic plans that cover necessities, price them fairly and affordably, and then require everyone that can to pay his own way.

The reality is quite different. In the private market, price and product design aren't political issues. Ford, GM, and Toyota can design, price, and service their cars in ways that work both for them and the customer. There are minimum standards, both health and environmental, and these costs are passed on to consumers, but since no one is forced to purchase a car, light truck, SUV, sedan, or motor scooter, issues of design and pricing rarely make it to the level of political and regulatory conflict.

Health insurance, as conceived by those on the left, is not really private insurance but social insurance and a predictable and reliable means to finance 16 percent of the United States economy.⁴⁹ There are billions of dollars at stake for physicians, hospitals, and investors when it comes to what will be included in the mandate.

Heritage has one view and the New America Foundation has another. The former advocates a bare bones risk transfer that seeks efficient ways to deal with the neighborhood effects of people who elect to not purchase insurance and then end up forcing costs onto others. The latter, wants a means to tax, spend, and redistribute through private companies in order to achieve desirable social ends that, nevertheless, would not occur if people were left free to make their own choices. Whose view will prevail?

In addition, if something is mandatory, then it is only reasonable that it must be of high quality and affordable. While mechanisms like the Massachusetts health care Connector may prove to be an excellent clearinghouse and a needed innovation, it is not simply a centralized marketplace that facilitates buying and selling among willing participants. The sellers will be offering a restricted, state-mandated product, a product that is sure to be expensive. The buyers, at least those who fall under various income limits, will be paying a price capped well below the cost of services they are expected to consume.

There will be some exceptions in product design for young adults ages 19 to 26, but even for this group it will likely be a fairly luxurious, and, therefore, expensive package. Providers of services — hospitals, drug companies, physician, and other health subspecialties like chiropractors and acupuncturists — all have an overwhelming financial incentive to lobby to get their reimbursement rates included. The consumer, not paying the total of his costs and not free to select less expensive and less generous offerings, will be frustrated either by poor product, high costs, or a combination of both.

Funded by taxes and tax penalties, what is essentially a social insurance system masquerading as a private marketplace will be put under tremendous stress. The calls will soon come for doing away with private insurance and moving to a government monopoly single-payer health care system funded by increased taxes. This has long been the goal of many, including Senator Ted Kennedy (D-MA) who enthusiastically assisted Romney in getting the package passed and is ushering it through Washington where it needs some waivers to “be effective.

Diamond in the Rough



THIS PAPER FOCUSES on the entire Massachusetts health bill, with an emphasis on the components that are most likely to further distort the health insurance market, increase taxes, and put the next brick in place on the path to government dominated health insurance. These features, especially the dual individual mandate and the play or pay provision for business, are surely the features that policymakers in the 49 other statehouses will rush to emulate. The law, however, builds some promising health insurance infrastructure.

Thinking of “health care” as a continuum of expected needs throughout one’s life, it becomes clear that the current insurance system, which is really prepaid medicine designed to process every health purchase through our employers due to tax favorability, is dysfunctional. If we were to start over and deliberately think through a system, we would consider two factors. While people are young, they tend to be healthy and therefore insurable, unlikely to spend large quantities on health care, and have other pressing needs for money, such as mortgages, education expenses, retirement savings, and general consumption. As we age, our health, as a rule, deteriorates, if only slightly. We become worse insurance

risks, and at some point, some of us become uninsurable. This is precisely the moment when our health expenses are the highest. Old age is not an insurable event, nor is poor health in old age. But it can be an event planned and budgeted for, and, therefore, not catastrophic. In addition, it has become customary in the United States to purchase health insurance with pre-tax dollars, an artifact of history and price controls that serves to cut the effective cost of insurance by as much as 45 percent.

This being the general outline, a system of offerings that combined the risk transfer of insurance with the tax-advantaged accumulation for old age would make the most sense. The life insurance model is instructive. A young and healthy person could lock into an individually-owned health insurance contract that would provide coverage until retirement. Premiums would not be level, but may increase slightly and predictably in one-or five-year increments, as is the case with some forms of life insurance. The policies would be guaranteed renewable, meaning the insurance carriers would agree not to drop a person or increase premiums should illness strike. A person would combine a side accumulation fund with this pure insurance, a health IRA or Health

Savings Account, into which money would be invested to accumulate for extraordinary expenses that may not be covered by insurance. Routine child birth might be an example for someone at a young age. Long term custodial health care, currently a financially catastrophic event for many Americans, is an example at more advanced ages. These arrangements would provide affordable and predictable lifetime expense and coverage for health risks. Being individually owned, it would also free up people to change jobs or create their own businesses without having to consider the consequences of changing insurance carriers or going without health insurance when they require it the most.

Such arrangements are impeded from emerging by the employer-based nature of our health insurance system, since employers, not individuals, own the underlying contract. The employer-based system is encouraged by the

generous tax breaks only available to employees who purchase their health care through their employers. Laws and regulations provide some portability of insurance policies, but nothing of the durability that would be desired for a lifetime of coverage.

The Massachusetts plan addresses this issue in an innovative way. The law creates a health Connector, a clearinghouse designed to match buyers and sellers of health insurance. More important, it promises to do this on a tax-advantaged basis, providing individuals with the same tax advantage if they purchase an individual plan through the Connector that they would have received had they secured a group plan through their employer. This is a promising innovation that if implemented properly, could assist in creating markets for the type of long-term private insurance arrangements that would provide real protection over a lifetime.

Conclusion



IF THE MASSACHUSETTS HEALTH PLAN LIVES UP TO ITS BILLING — universal coverage with no increased taxes and no government takeover — it will indeed be a model for other states to follow. There are strong reasons to expect, however, that the plan will, in fact, lead to higher costs and increased effective taxes, on both businesses and individuals. Given the results of the November 2006 election and the election of Democrat Deval Patrick as Governor, these outcomes are even more likely. The plan mandates generous, highly subsidized coverage that does nothing to encourage cost control from the users of health care. It offers only limited relief from the state's onerous health insurance regulations. The problems it allegedly addresses — adverse selection in the individual health insurance market and the resultant cost shifting from the voluntarily uninsured, are themselves caused by state regulation left in place. At best, an individual mandate will serve as a new tax on Massachusetts' citizens, albeit one collected, at least initially, by private parties. At worst, it will serve as an excuse to further regulate health insurance, control prices, and build pressure for a total government solution. The health care Connector, a central clearinghouse for individually owned and portable insurance, is a real innovation, and one that, if implemented properly, will add value to the residents of Massachusetts. The Connector's success will likely be limited by the tightly-regulated products that the state will allow to be offered. At present, state bureaucrats, health insurers, hospitals, and consumer advocates are scrambling to figure out what the bill means in practice, what it requires, and what it allows.

In the months since the Governor's April signature, Massachusetts health reform has started to take shape. Whether that shape will be sleek, responsive, and efficient, or bloated, impenetrable, and bureaucratic will depend on much behind-the-scenes wrangling over the next few months, and beyond.

We continue to watch with concern.

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SALLY C. PIPES is president and chief executive officer of the Pacific Research Institute, a San Francisco-based think tank founded in 1979. Prior to becoming president in 1991, she was assistant director of the Fraser Institute, based in Vancouver, Canada.

Ms. Pipes addresses national and international audiences on health care, women's issues, education, privatization, civil rights, and the economy. She has been interviewed on CNNfn, "20/20," Fox News, "The Today Show," "Dateline," "Politically Incorrect," "The Dennis Miller Show," and other prominent programs.

She has written regular columns for *Chief Executive*, *Investor's Business Daily*, and the *San Francisco Examiner*. And her opinion pieces have appeared in the *Washington Post*, *USA Today*, *Financial Times of London*, *New York Times*, *Los Angeles Times*, *San Francisco Chronicle*, *Sacramento Bee*, and *Boston Herald*. Recently, she was quoted in *Shape Magazine* for her support of Consumer Directed Health Care.

A Canadian residing in the United States, Ms. Pipes has participated in prominent debates and public forums, testified before five committees in the California legislature, appeared on popular television programs, participated in talk radio shows nationwide, and written several dozen opinion pieces on health care reform. Topics have included the false promise of a single-payer system as exists in Canada, pharmaceutical pricing, solving the problem of the uninsured, and strategies for consumer-driven health care.

Her book, "Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer" was released September 28, 2004. It is available on Amazon.com. Hillsdale College published her essay on health care reform in the 2006 edition of *Champions of Freedom*. It was part of a conference on "Entrepreneurship and the Spirit of America". She also co-authored with Spencer Star *Income and Taxation in Canada* and co-authored with Michael Walker seven editions of *Tax Facts*.

Ms. Pipes has held a variety of positions in both the private and public sectors. In British Columbia, the Ministry of Consumer and Corporate Affairs appointed her director and vice-chairman of the Financial Institutions Commission. She also served on the Vancouver City Planning Commission.

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She received the Roe Award at the 2004 annual meeting of State Policy Network. The award is a tribute to an individual in the state public policy movement who has a passion for liberty, a willingness to work for it, and noteworthy achievement in turning dreams into realities. In 2005, she was named one of the Top 10 Women in the Conservative Movement in America as published by *Human Events*. She was also featured in a new book *Women Who Paved the Way* as one of 35 most outstanding women in business in the nation.

Ms. Pipes is a member of the Mont Pelerin Society, National Association of Business Economists, and the Philadelphia Society. While in Canada she was a member of the Canadian Association for Business Economics (president for two terms) and the Association of Professional Economists of B.C.



About the Pacific Research Institute



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