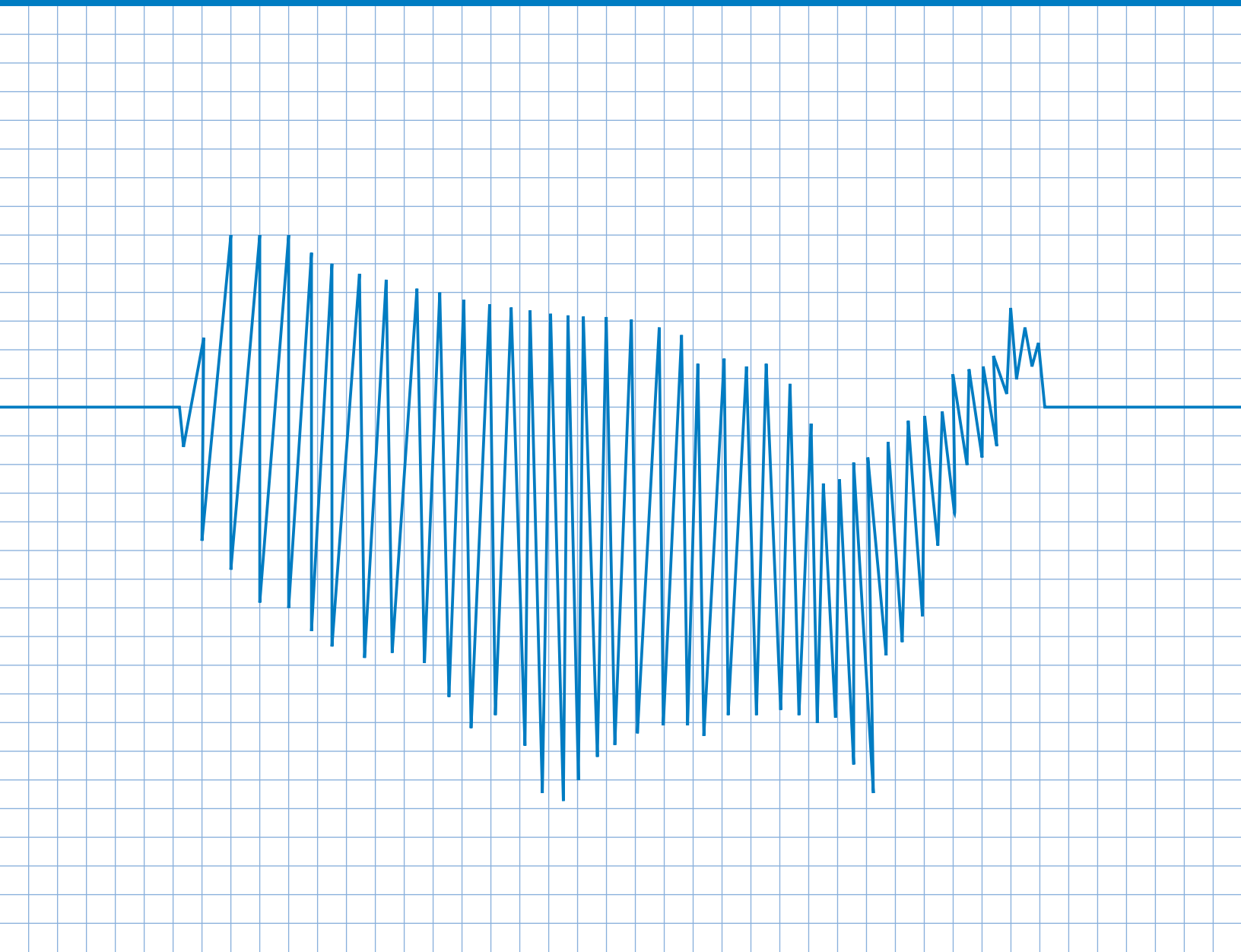


2008
U.S. INDEX OF
Health Ownership

2ND EDITION

BY JOHN R. GRAHAM

with a foreword by Glenn Hubbard



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by John R. Graham
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PRIVATE HEALTH INSURANCE CATEGORY RESULTS

Table 5: Ordinal Ranking of State Private Health Insurance					
Rank	State	Score	Rank	State	Score
1	Iowa	6.55303	26	Alaska	23.47727
2	North Dakota	10.62879	27	Wyoming	23.54545
3	Alabama	11.31061	28	Pennsylvania	25.25000
4	Idaho	11.47727	29	Oregon	26.00000
5	Nebraska	12.21970	30	Georgia	26.23485
6	Wisconsin	12.22727	31	Virginia	26.24242
7	Utah	12.71212	32	Washington	26.25000
8	Kansas	13.05303	33	Delaware	26.28788
9	Hawaii	16.14394	34	West Virginia	27.09091
10	Indiana	17.73485	35	New Hampshire	27.27273
11	South Carolina	17.81061	36	Colorado	27.62121
12	Missouri	17.88636	37	New Mexico	28.48485
13	Michigan	18.16667	38	Florida	28.92424
14	Arkansas	18.72727	39	Connecticut	29.53788
15	South Dakota	18.79545	40	Louisiana	30.36364
16	Illinois	20.13636	41	North Carolina	30.71970
17	Minnesota	20.98485	42	Texas	31.14394
18	Kentucky	21.04545	43	California	31.26515
19	Mississippi	21.26515	44	Nevada	31.82576
20	Montana	21.30303	45	Vermont	34.59091
21	Oklahoma	21.96212	46	Rhode Island	36.12121
22	Ohio	22.48485	47	Maine	37.25758
23	Tennessee	22.83333	48	Massachusetts	38.34091
24	Maryland	22.87879	49	New Jersey	39.35606
25	Arizona	23.15909	50	New York	42.17424

Foreword

Who owns your health care? That should not be a difficult question. Surely, in the United States, everyone should own his own health care. Unfortunately, that is not the case. Much of the public dialogue about our health care “crisis” actually revolves around that issue. When we look at the choices we make—how to earn a living, what kind of a home to establish for our family, or what to do with our spare time—we are freer than any other people in history.

However, when it comes to health care, a matter of such intense personal concern that we might reasonably expect to be free to pursue it without interference, such is not the case. Often in the name of the “public good,” the state has inserted itself in ways that Americans would utterly reject in other areas of their lives. Today, almost half of our health care spending is determined directly by government—instead of by patients themselves. The other half is restricted by a bewildering morass of regulations on payers and providers which nobody can hope to understand fully—with the result that one-quarter to one-third of our health spending is wasted.

Politicians created this system—the most expensive in the world—and they continue to add on more and more layers of government control—usually in order to fix problems that they created themselves by interfering in our freedom to use our own resources to acquire the health care we need.

Until now, ordinary citizens have been unable to grasp the magnitude of this interference by the state. With the launch of the U.S. *Index of Health Ownership*, they now have a measurement tool to help them understand how politicians, especially at the state level, have infringed upon their health ownership.

Using 24 variables, six for each of four areas—Medicaid, private insurance, the legal system, and regulation of health providers—John R. Graham of the Pacific Research Institute has given shape to the true magnitude of our lack of health ownership. This *Index* gives ordinary Americans the information they need to hold the politicians to account for what they have done, and continue to do, to our health system.

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 (IHOP)* measures 24 variables in four categories: government health care, private health insurance, medical tort, and provider burden of regulation.
 - Alabama, Montana, Nebraska, North Dakota, and New Hampshire are the top five: states that allow their citizens relatively more health ownership. However, even in these states, the level of government control is far greater than necessary.
 - New York, Massachusetts, Rhode Island, Vermont, and North Carolina are the bottom five: states in which the government has taken relatively more 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.
-

WHAT IS "HEALTH OWNERSHIP"?

In a recent survey, Americans named health insurers, managed care companies, and drug makers as being the least trustworthy organizations in the country. Between 40 and 50 percent of the respondents thought that operators in these industries needed to be "more strongly regulated."¹ However, these industries are already grossly overregulated. The costs of health regulation outweigh their benefits by two to one, according to Professor Christopher J. Conover of Duke University. Furthermore, these regulations kill 4,000 more Americans annually than die from lack of health insurance: 22,000 versus 18,000.²

Approximately two-thirds of this deadly burden comes from state governments. IHOP 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, as well as 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 receives living assistance from a nursing aide in her home. State Medicaid bureaucrats decide whom to send into her home, irrespective of whether the Medicaid beneficiary prefers 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 want to invest in a clinic where they can conduct operations pertinent to their specialty. The local acute-care hospital invokes state power to prevent this.
- An obstetrician, mindful of research that indicates caesarian sections should be performed only in certain cases, nevertheless performs them to a much greater degree than warranted, because not doing so puts him at serious risk of being victimized by a baseless, but nevertheless costly, medical malpractice suit.
- A nurse practitioner wants to establish a clinic to treat patients within her scope of competence and professional ethics, at low cost, 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 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

IHOP quantifies issues previously introduced in a collected volume of seven chapters, *What States Can Do to Reform Health Care: A Free-Market Primer*, published two years ago, and 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 villains in health care. 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 that operators in these industries needed to be “more strongly regulated.”⁶ The truth is, however, that these industries are already grossly overregulated.

The costs of health regulation outweigh their benefits by two to one, meaning that the total burden of health regulation in the United States, as of 2002, was \$169.1 billion annually, or an average of \$1,500 per family, according to Professor Christopher J. Conover of Duke University. Furthermore, 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 (on administration of the Health Insurance Portability and Accountability Act [HIPAA] and insurance privacy) 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
Health Facilities	\$25,074	\$15,409	61%
Health Professionals	\$7,133	\$1,857	26%
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 that they favor, whereas citizens who prefer to be left alone will not have satisfactory incentives either to inform themselves about the harm being done to them or to organize democratic resistance against the government intrusion.⁹

These costs, however, are clearly significant. The concept of "health ownership" is meant to facilitate citizens' understanding of these burdens on their freedom to engage health resources, and IHOP provides relatively straightforward measurements to help them understand the role of their state governments in this problem, and demand improvement.

The examples above make it clear that state governments are subject to interests that cause them to enact 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 ownership 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 adapted a number of them in designing IHOP, if not by using their techniques then by embracing their principles. In some cases they contributed inputs to IHOP.

The first indices produced by scholars who advocate 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. The product of intellectual inquiry since the late 1980s, this project reaches back as far as 1970 (for some countries) to investigate and measure attributes of economic freedom in the nations of the world. These attributes are defined as:

- Personal choice,
- Voluntary exchange controlled by markets,
- Freedom to enter and compete in markets, and
- Protection of persons and their property from aggression by others.¹⁰

Clearly, there is a relationship between health ownership and economic freedom. *Economic Freedom of the World* measures 38 categories of data for each country. Over the last decade, a large number of peer-reviewed articles, published in the 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 for mankind.¹²

Economic freedom having been measured across countries, the next step was to measure it across states. In 1999, scholars at Clemson University published the first such measurement.¹³ The same year, scholars at the Fraser Institute produced a comparison of economic freedom of individual Canadian provinces, which has been followed by *Economic Freedom of North America*, including both Canadian provinces and American states.¹⁴ The latter employs 10 variables and uses 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, Clemson scholars teamed up with a colleague at the Pacific Research Institute (PRI) to expand and update the 1999 study. They found 47 variables that explained changes in annual income per capita, finding that a 10-percent improvement in a state's economic freedom explains about a half-percent increase in income per capita, on average. They also found that this measurement of economic freedom explained net migration of people between states: people move from economically unfree states to those that are free.¹⁵

Undoubtedly because of the number of years and the serious intellectual firepower invested in understanding economic freedom, these indices are impressive statistical and prescriptive achievements. Using regression analysis and other econometric tools, they have succeeded in determining causal relationships. That is, they answer the question: "Does X cause Y, and by how much, and what might explain the rest of Y?"

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

Dr. Lawrence J. McQuillan of PRI, who collaborated on the updated study of economic freedom of the states with the team from Clemson University, and a PRI colleague, Hovannes Abramyan, followed up with an index of tort liability. This 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, lives saved, greater innovation, and other beneficial effects.¹⁶

The latest *U.S. Tort Liability Index* weighs 41 different variables, grouped into five categories. Thirteen of the variables are outputs from the tort system such as monetary losses and litigation risks. The remaining variables are inputs (rules and reforms) that shape tort system outcomes. The input

reforms include caps on noneconomic damages and punitive damages and changes to venue requirements and class action certification rules. Why bundle inputs and outputs in one index? As one of the authors' sources notes, there is a feedback loop between inputs and outputs that has a significant time lag. Nevertheless, the index shows where states stand today in terms of tort outputs and reform. States with better rankings in tort liability 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 laypersons to understand and therefore perhaps more important for policy formation than more academic efforts. For example, the Heritage Foundation has periodically produced an *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, has the civil society yielded substantial ground to the federal public sector?"¹⁷ While I have not used this index as an input (because it is a national, not a state-based measurement), I share the author's enthusiasm for the idea that social services should be provided by governments closer to the people, state and local, than 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. Therefore, these fellow citizens necessarily have limited health ownership, according to these criteria. This invites the question of how we transfer resources from those who do not "need" help to those who do. The answer given by governments today appears to be: As far away from their communities as possible, using language and rules impenetrable to members of those communities, and inflexible to the nuances and idiosyncrasies of communities encompassing more than 300 million souls and constituting 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 policy makers— even at the county level—must often secure permission from the Centers for Medicare & Medicaid Services (CMS) in Baltimore, Maryland, before their decisions take effect. This means that the government of a state is less accountable to its own residents for how it spends money on the state's government health programs than it is to residents of other states, obviously an unsatisfactory situation because such "accountability" is neither appropriate nor practical.

This has led to out-of-control spending on these 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*, IHOP favors states that are relatively more dependent on their own taxpayers to finance these services than on taxpayers of neighboring 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 than it was circa 1960, and relatively stable from 1988 until the early 21st century. This index, easy to explain and understand, was published by the *New York Times*, thus exposing millions to its message and having great impact.¹⁹

There are a number of measurements of health-system performance across the states (some of which are included in IHOP), but most do not directly address the question of individual sovereignty in health care. Indeed, many that compare the states adopt a very different perspective—embracing, rather than resisting, government intrusion.²⁰ Those that do resist government intrusion, I have adapted for inclusion in IHOP. These include measurements of the burden of regulation 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 conducted 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).²¹ Although the study does not use the term “health ownership” or anything similar, it does measure aspects of health-system governance that fit the bill. For example, it asks: Do countries force taxpayers to bear all the cost of an individual’s health care (“first-dollar coverage”)? Are patients able to direct their dollars, yen, or euros to providers of their choice? 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, consider such questions somewhat off the mark, because we understand it to be the case that private insurers can compete, governments do not run most hospitals, and doctors’ pay is not determined by the state. However, state governments have a significant effect on the conditions under which these parties operate, analysis of which is the point of this study. Nor should we take these matters for granted. In California, a bill was passed by both houses of the

legislature in 2006 that would have abolished all this in favor of government monopoly. Fortunately, Governor Schwarzenegger vetoed this potentially disastrous legislation.²²

Another international effort to measure factors similar to what I call health ownership has been undertaken by Europe's Health Consumer Powerhouse, a research institute in Brussels. This effort started at the subnational level. Since 2004, the Health Consumer Powerhouse has published a ranking of what it calls "system indicators" for Sweden's 21 counties.²³ Like PRI's *Tort Liability Index*, it measures both inputs and outputs and combines them in one measurement of performance, ranking Swedish counties from best to worst. Similarly, the Health Consumer Powerhouse ranks 25 European countries. The *Euro Health Consumer Index 2007* examines 28 indicators of "how the health care consumer is being served by the respective systems."²⁴

Because of the nature of European health care systems, the indicators in these reports are not really "health ownership" as IHOP understands it. The authors basically accept that the patient is on the receiving end of whatever the government thinks he deserves, and focus on his right to understand what is going on, and if necessary to appeal, rather than take his money and go elsewhere for treatment. Their 10 questions, for example, include: Are patients' rights organizations involved in decision making? Is there a patient ombudsman? Does the patient have access to his own medical record? This European index focuses only on the consumer, not on the freedom of all actors in the health space to operate with limited interference by the state, which IHOP also addresses.

This year, the Health Consumer Powerhouse combined with a Canadian institution, the Frontier Center, to launch a combined *Euro-Canada Health Consumer Index* "that treated Canada like any European state."²⁵ This new international comparison competes directly with the Fraser Institute's effort.

As readers go through IHOP, they may ask whether there can be a conflict between economic freedom and health ownership. After all, economic freedom depends on low taxes, amongst other things, and IHOP 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, if we are operating within this sphere, we have implicitly accepted a certain degradation of economic freedom.

I have dealt with this before within the context of another comparison of health indicators grounded in the principle of personal freedom and responsibility. This involved a study of Canadian provincial pharmaceutical benefit plans, in which 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.²⁶ Mindful that more money spent on medicines (newer ones especially) is associated with reduced hospitalization and other health costs, we simply faced them off against each other and found that the amount of taxpayers' money spent on these benefits was somewhat less important than how the subsidy was designed. Within the Canadian context, if a pharmaceutical benefit plan gave first-dollar (or almost first-dollar) coverage, it had a lot more difficulty controlling costs, and therefore was more likely to

restrict patients' and doctors' choice of medicines, than if it functioned more as a catastrophic insurer, in which case costs were likely easier to predict and more choice in medicines was feasible.²⁷

With respect to this effort, IHOP has indicators that point in the same direction as economic freedom. Given the "fact" of government health programs, other indicators point in the direction of maximum patient choice within the limits of those programs. IHOP is contrarian in that it bucks the trend of modern society continually to 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, but the report also includes government health programs in its rankings as a positive factor, obviously in opposition to the principle of individual health ownership.²⁸

Once again, IHOP enters an environment where champions of freedom in the United States have compared indicators of economic freedom and tort liability here, while 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. IHOP also enters an American health policy environment dominated by calls for unlimited government spending, co-ordination, standard-setting, and general rule-making that restrict freedom of action in health care.

I trust that it 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 IHOP. Each variable's observations for a state are either discrete measurements or continuous standardized frequencies, the same two ranking methods used by my colleagues in their *Tort Liability Index*.²⁹ If the variable measures discrete observations, the possible number of discernible 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 1st to 50th.³⁰ Of the 24 variables, 12 are discrete and 12 continuous.

Table 2: Categories and Variables	
I. Government Health Care	14. Caps on Damage Awards in Medical Malpractice Lawsuits, 2007 [21]
1. Medicaid Innovation: Waivers, 1987–2008	15. Medical Malpractice Attorney Fee Limits, 2007 [15]
2. Prescription Share of Medicaid Spending, 2004	16. Conditions on the Use of Expert Witnesses in Medical Malpractice Lawsuits, 2007 [5]
3. Medicaid Managed Care Enrollees' Share of Total Medicaid Population, 2006	17. Medical Malpractice Pre-Trial Screening or Arbitration, 2007 [6]
4. Medicaid Freeloading, 2004	18. Statute of Limitations on Medical Malpractice Lawsuits, 2007 [5]
5. Medicaid Income Eligibility, 2008	
6. SCHIP Enrollment Increase, June 2002–June 2007	
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, 2006
8. Burden of Mandates, 2008	20. Burden of Facility Certificate-of-Need (CON) Regulation, 2007 [34]
9. Percent Uninsured, 2005–2006	21. Corporate Practice of Medicine, 2003 [5]
10. High-Risk Pool, 2006 [12]	22. Telemedicine Licensure, 2003 [8]
11. Individual Premiums, 2006–2007	23. Nurse Practitioner Prescribing Autonomy, 2008 [5]
12. Small Group Premiums, 2005	24. Nurse Practitioner–Physician Relationship, 2008 [9]
III. Medical Tort	
13. Medical Malpractice Insurance Losses/Projected Personal Health Care Expenditures, 2007	

The variables are grouped into four categories of six: (I) government health care, (II) private health insurance, (III) medical tort, and (IV) provider burden of regulation. These four categories 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 benefit fully from that aspect of health freedom, because innovative suppliers of health care are unable to compete to serve their preferences. 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 IHOP encourages policy makers to improve all categories of health ownership by using the relatively easily measured levers provided here.

Selecting the variables proved challenging. From hundreds, we picked those with the two characteristics of importance to health freedom and relative ease of measurement, thus facilitating citizens' and policy makers' ability to understand and change them. Where appropriate, IHOP 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.³¹ Because states have interfered with their citizens' health ownership, which is the "state of nature," these interventions presented themselves for examination. IHOP 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*.³² Evidence put forward in this book, and in other sources, is cited below for each variable, supporting that variable's inclusion in this measurement of health ownership. These variables provide a basis for action by state policy makers to improve the level of health ownership for their citizens, and for citizens to demand such action.

I. GOVERNMENT HEALTH CARE

These variables measure how the state manages its health welfare programs, Medicaid and the state children's health insurance plan (SCHIP). They examine both innovation and the growth of such programs. The historical capacity of a state to innovate within these programs is likely a leading indicator of 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.³³

1. Medicaid Innovation: Waivers, 1987-2008. 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 funding from the federal government when they expand the program. That is, when a state program grows by one dollar, the federal government throws in at least another dollar. Thus, state governments can buy political capital and government growth via a two-for-one deal.³⁴ Unfortunately, both taxpayers and Medicaid beneficiaries suffer, because the overarching goal of state politicians and bureaucrats is to pull federal money into the state; they are not 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 federal matching payments. Thus, the state takes more responsibility for its own Medicaid population. Obviously, this description is a great oversimplification. Because this variable is the only one “freshly baked” for IHOP, I will explain it in more detail.

There are basically three types of waivers. Section 1115 waivers are for research and demonstration projects, which generally last 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 subsidizes 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 to “carve out” delivery systems for specialty care. Section 1915(c) Home and Community Based Service waivers are designed to offer flexibility of care both in traditional medical settings and in non-medical settings, including using family members as caregivers.³⁵ Obviously, all these waivers increase health ownership, while the fiscal conditions limit taxpayers’ liability.

From 1987 to early 2008, states earned 414 of these waivers, including pharmacy waivers and excluding waivers specific to Hurricane Katrina.³⁶ IHOP cannot measure the effectiveness of each waiver, and I have little doubt that some were disastrous. Nevertheless, they are a measurement of Medicaid innovation, which is valuable to health ownership, and bad waivers can die a painless death.

IHOP scores states using a three-step process. First, all waivers earned by a state are counted and weighed (linearly) by the year granted. A waiver granted in 2007 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. We also note that many promising waivers are pending approval, and we look forward to including them in the future.

So far, this is the same method as used in the first edition. However, we also improved the previous measurement by adding weight to states that have had waivers modified (in a positive way, not by abandoning them) in the last two years. This compensates for the bias in the original measurement against states that have old waivers, but keep renewing and modifying them, which we have come to believe can be just as effective as applying for brand new waivers.

This score is then adjusted twice. First, it is adjusted for the size of the population. A populous state will tend to have more waivers because of its size. It likely has a larger state 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. A second adjustment is necessary, however, because the first has a bias in favor of states with small populations and much geography: Alaska leaps to the front. Alaska would reasonably be expected to have a greater natural need for waivers to meet local conditions 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. These data come from the Centers for Medicare & Medicaid Services.³⁷ Evidence supports the value of pharmaceutical versus other health spending. As explained in *IHOP*'s companion volume, focusing on containing pharmaceutical costs has the effect of "squeezing the balloon," because increased expenditures on prescription drugs, especially newer, more innovative ones, are greatly outweighed by savings in payments to physicians and hospitals.

This factor may also be considered one proxy for determining whether a state's politicians are focusing their energy on effective health reform or wasting it on trivialities. Such trivialities often focus on pharmaceutical cost containment. For example, New York (which once again ranks at the bottom of *IHOP*) has a legislature that is frittering away its time considering bills such as A.11187, which seeks to reduce pharmaceutical spending by making it illegal for physicians to receive gifts from drug makers valued at more than \$50. Bills like this squander legislative time that would be better spent on consumer-directed reform.

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.³⁸ Accentuating this problem, Medicaid populations have characteristics making them even more appropriate candidates for newer, more expensive medicines than the general population.³⁹ 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, 2006. Using data from the Kaiser Family Foundation, this variable measures the share of Medicaid beneficiaries enrolled in Medicaid managed care programs: the more the better.⁴⁰ This is related to variable 1, because waivers are often used to move beneficiaries from traditional, fee-for-service Medicaid to managed care programs. Like variable 1, this one would be improved by more precise information: I have no doubt that many Medicaid managed care programs are disastrous. Tennessee's TennCare is a grim example that has led one free-market health policy analyst to denounce Medicaid managed care in *toto*.⁴¹

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 2006, the share of Medicaid beneficiaries nationwide enrolled in managed care increased from 40 percent to 65 percent.⁴²

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 in 2006.⁴³ 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 also associated with savings for the states, especially with respect to disabled Medicaid beneficiaries.⁴⁴

Medicaid managed care does not fully avoid the problems of traditional Medicaid. It is not as if beneficiaries had vouchers 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 hospitalization, but lower satisfaction for patients and self-reported delay in getting care.⁴⁵ 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.⁴⁶

The literature on Medicaid managed care does not speak with one voice.⁴⁷ Nevertheless, there are a number of positive examples. 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.⁴⁸

4. Medicaid Freeloading, 2004. This is a measure of federal Medicaid matching funds relative to poverty in a state and therefore the state's ability to pay its own way without raiding the federal Treasury. A major 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.⁴⁹ The federal Treasury, of course, has only the money taken from all 50 states, so states are really just picking one another's pockets in a zero-sum bureaucratic game.

This variable is the first (but not the last) that depends entirely on the insight and analysis of others, in this case, John Goodman and his 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 federal matching funds each state receives than it “deserves,” based on the number of poor people it has.⁵⁰ In the first edition of IHOP, we used the results of their regression analysis as our source. Their analysis used federal Medicaid dollars, personal income per capita, and poverty population in each state in 2004; and personal health care expenditure per capita in each state in 2001. For this edition, we were able to update the latter using 2004 personal health expenditure per capita data not available to Goodman and colleagues at the time of their analysis.⁵¹

This is truly a measure of freeloading. Nevada and the Dakotas get ripped off (to use the technical term), while Alaska, New York, and Vermont have their hands deeper in other Americans’ pockets than they reasonably deserve. This variable is a negative indicator: even if one thinks that Medicaid is good for poor people, the states that take too much reduce their residents’ health ownership by expanding this welfare beyond the appropriate demographic limits.

5. Medicaid Income Eligibility, 2008. The federal matching formula creates a perverse incentive to expand Medicaid frantically, which results in more higher-income Americans 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.⁵² Curiously, politicians seem proud of expanding Medicaid, and there is not nearly enough movement in the direction other welfare programs went a decade ago.

This variable measures the income eligibility for Medicaid in a simple way: adding the federal poverty line (FPL) cutoffs for various groups reported by the Kaiser Family Foundation’s Statehealthfacts.org online database.⁵³ The database divides the population into six demographic groups and reports their FPL cutoffs. For example, Alabama takes first place in this ranking, with a raw score of 536 percent, which equals 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 cutoffs of 1,655 percent. In Minnesota, basically everybody earning less than 275 percent of the FPL is eligible for Medicaid.

6. SCHIP Enrollment Increase, June 2002–June 2007. 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 Statehealthfacts.org database.⁵⁴ States that resisted the urge to expand their children’s health insurance programs rank high. Indeed, between 2002 and 2007, 16 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.⁵⁵ In the first edition of *IHOP*, we relied on a CAHI publication from October, 2006, which compared health insurance regulations in all the states, to derive our six variables in this category.⁵⁶

CAHI weighed its variables differently, whereas here they are weighed equally. And CAHI does not rank the states with the granularity that *IHOP* seeks, but merely 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 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 between states that CAHI’s authors did not consider significant. (Indeed, they warn against it.) Nevertheless, this is consistent with the method used throughout *IHOP*, and as neither CAHI’s nor my effort claims to be a statistical exercise, neither method is obviously superior.

CAHI has not updated its October 2006 *State Health Insurance Index*, but we were able to update four of the six measurements from other sources. For two indicators, numbers 7 (burden of regulation) and 10 (high-risk pool), we were unable to find superior data, so we continue to use CAHI’s original measurements. However, CAHI has given us to understand that it will be publishing updates regularly, which we hope to continue using as inputs.⁵⁷

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 HIPAA 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 small group market: 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 expensive beneficiaries. 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, 2008. This tallies the number of mandates that a state imposes on health plans. Examples are mandating drug and alcohol abuse treatment, blood-lead poisoning treatment, or massage therapy, and including noncustodial children in a family. The number of mandates ranges from only 13 in Idaho to 62 in Minnesota. Because mandates increase the cost of health insurance and force the insured to buy unneeded and unwanted coverage, more mandates equal less health ownership. The cost of mandates is difficult to assess; this is the topic of *From Heart Transplants to Hairpieces*, a research paper by the Pacific Research Institute.⁵⁸ The source of this measurement is the latest state-by-state breakdown of mandates published by CAHI.⁵⁹ For this edition, we have refined the scores somewhat. CAHI breaks mandates down into a number of categories by cost, and we assign heavier weights to those that add at least 3 percent to the price of a policy, medium weights to those that add between 1 and 3 percent, and light weights to those that add less than 1 percent. In the first edition of IHOP, we weighed all mandates equally.

9. Percent Uninsured, 2005–2006. 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. This variable simply scores the states by the proportion of the non-elderly residents (up to 64 years of age) without health insurance, as presented by the Kaiser Family Foundation using data from the *Current Population Survey (CPS)*.⁶⁰ As discussed elsewhere, counting the uninsured through the CPS is fraught with possibilities for misunderstanding.⁶¹ Nevertheless, it is the most commonly used measurement, and IHOP is concerned with ranking, not the accuracy of absolute measurements.

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 sick) to be able to find affordable private health insurance. A good high-risk pool will 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 (drawing on another primary source):

- Is the pool closed or open to new entrants? Obviously, an open pool provides a better safety net.
- Are the premiums low enough to lead 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 out 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.)

As with variable 7, Burden of Regulation, we continue to use the same measurements as we did in the first edition.

11. Individual Premiums, 2006–2007. In the first edition of *IHOP*, we adhered to the CAHI authors’ judgment that insurance premiums should be graded discretely, because they considered that small differences in premiums were not “real,” given the need to triangulate among different sources. Because CAHI has not updated its *Index*, we tapped a more recent source, a survey by America’s Health Insurance Plans (AHIP), and graded the premiums continuously, as AHIP reported them.⁶² We used the annual family premium in the individual market, adjusted for the average family size in each state.

In the first *IHOP*, we scored the states by quintiles, as CAHI did, accepting that reported average premiums were likely not accurate enough to reflect real differences. For example, last year’s data included average premiums of \$2,295 for Nebraska and \$2,299 for Missouri. Surely, we agreed, they should be given the same score. However, after consideration and discussion, we concluded that scoring states by quintiles introduces an even bigger problem, because it creates huge scoring gaps between the “border states.” For example, if Nebraska was at the bottom of the top quintile it would get a score of 1; whereas Missouri, at the top of the second quintile, would score 13.25. If scored continuously, they score 10 and 11, bringing them much closer together.

This change created significant instability in this variable between the first and the present editions of *IHOP*. Where states have moved up or down significantly in the rankings, it is usually because of this change in measurement: California is the leading example of this effect. Nevertheless, we believe the change is warranted, and future editions will exhibit more stability in this variable.

AHIP did not report these figures for six states. However, for Delaware, New Mexico, and Washington, it did report the average premium for single policies, so we simply grossed these figures up

proportionately. For Alaska, CAHI's previous *Index* reported that too few policies were sold to yield a reliable figure, so we simply entered the national average. For Vermont, CAHI's previous *Index* reported that the individual market is so overregulated that it cannot really be said to exist, so we "forced" the highest premium for that state. For Hawaii, we took the premium reported previously by CAHI and grossed it up by the same proportion as the state with the closest premium to Hawaii's, that is, West Virginia, increased for this edition.

12. Small Group Premiums, 2005. The idea here is exactly the same as for variable 11. In the first edition, we used the gradations published by CAHI. In this one, we go directly to the 2005 Medical Expenditure Panel Survey (MEPS), as reported by the Kaiser Family Foundation, and use continuous indicators. The premiums are the average total premium for employer-sponsored health insurance in 2005 in each state. The total combines the shares paid by the employee and the employer for a family policy. Although these figures are the most accurate available, they must be interpreted with caution, because health insurance is structured differently in different states, and so there may be some comparison of apples to oranges here. For example, California has a far greater presence of HMOs than Michigan.⁶³

As with the previous variable, we changed the scoring from discrete to continuous, creating instability in the measurements between last year's IHOP and this one.

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 IHOP, Jim Copland of the Manhattan Institute discusses the evidence for this.⁶⁴ Specifically:

- Since 1975, medical malpractice costs have risen four times as fast as general 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. Of the 41 variables in that index, six are appropriate for use in IHOP.

13. Medical Malpractice Insurance Losses/Projected Personal Health Care Expenditures, 2007. For this variable (number 6 in the *Tort Liability Index*), McQuillan and Abramyan divided

monetary medical malpractice losses by projected personal health care expenditures as reported by the National Health Expenditures Database of the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services. (This is a slight change from the previous edition, where the denominator was the gross state product). The division enables 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.⁶⁵

14. Caps on Damage Awards in Medical Malpractice Lawsuits, 2007. This variable (number 17 in the *Tort Liability Index*) examines whether a state limits damages or requires a higher negligence standard for medical malpractice, using a number of sources. Capping these awards is associated with doctors performing less defensive medicine and with lowering medical costs five to nine percent without significant increases in complications or mortality—a significant increase in health ownership.⁶⁶ According to McQuillan and Abramyan, limits on medical malpractice damages stand alone in some states, but other states make them dependent on a number of factors. For example, in West Virginia, limits rise for inflation and are applicable only to physicians who carry at least \$1 million in medical malpractice insurance.⁶⁷

15. Medical Malpractice Attorney Fee Limits, 2007. 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, courts approve each party's legal fees based on perceived reasonableness. McQuillan and Abramyan use two sources for their data (variable 27 in their *Tort Liability Index*).⁶⁸

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 three percent after three years, through increases in both the number of doctors entering practice and the number delaying retirement.⁶⁹

16. Conditions on the Use of Expert Witnesses in Medical Malpractice Lawsuits, 2007. This variable (number 38 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.⁷⁰ 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 specialty similar to the defendant's and be up-to-date in that specialty.⁷¹

17. Medical Malpractice Pre-Trial Screening or Arbitration, 2007. Both pre-trial screening and arbitration are ways to avoid an unnecessarily costly medical malpractice court case. The former is a hearing to determine if a case is valid, while the latter is an alternative to a trial conducted by a disinterested party. Pre-trial screening reduces the number of cases without merit that clog the

courts.⁷² Arbitration increases the likelihood of the two parties reaching a mutually agreeable settlement. Nebraska, for example, requires a review by a medical review panel before a case may proceed to trial. Oregon requires all parties to participate in dispute resolution within 270 days of an action being filed, unless the case has already been settled or all parties voluntarily waive mediation or arbitration. This variable (number 28 in the *Tort Liability Index*) uses data from two sources to score states on how well they use these two valuable options.⁷³

18. Statute of Limitations on Medical Malpractice Lawsuits, 2007. States can implement statutes of limitations for medical malpractice. Indiana, for example, has a two-year limit, and Kentucky imposes a one-year limit after the act or reasonable discovery, but not more than five years after the act. Using data from two sources, this variable (number 39 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 line between cause and effect can still be clearly drawn.⁷⁴ These limits increase health ownership by lowering legal costs for physicians.⁷⁵

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 also be reformed. There is not much point in having an empowered patient if health entrepreneurs are not free to compete. Thus, IHOP 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, 2006. IHOP 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 in the behavior of the two types of facility, but I do not view the matter as settled.⁷⁶ 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.⁷⁷

However, there is really 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, despite often having higher costs.⁷⁸ Using data from the Kaiser Family Foundation's Statehealthfacts.org database, which sources data from the American Hospital Association, this variable ranks states according to the proportion of hospital beds owned by state and local government, favoring states with less public ownership. Data include staffed beds for community hospitals, which represent 85 percent of all hospitals. Not included are federal hospitals, long-term-care hospitals, psychiatric hospitals, institutions for the mentally retarded, and hospitals for alcoholism and other chemical dependencies.⁷⁹

This variable illustrates the trade-offs implicit in normalizing the measurements continuously on a scale of 1 to 50, instead of discretely. Wyoming scores the worst, with 72.8 percent of hospital beds owned by state or local government, which gives it a score of 50. However, Alabama, the next worst, scoring 49, has only 45.1 percent of beds under local or state government ownership. The gradations between Alabama and the other 48 states that perform better are much slighter than the whopping 27.7 percentage points that divide it from Wyoming. One might conclude that Wyoming should be “punished” far more than just one point on the scale for such massive government ownership of hospitals. Indeed, we considered grading this indicator discretely. However, this would have introduced the problem identified above, in number 11 (individual premiums). Indeed, Wyoming might have idiosyncratic characteristics that cause this extreme outlier, perhaps related to its very small population living in a very large state. Normalizing the measurement accounts for any such unobserved idiosyncrasy.

20. Burden of Facility Certificate-of-Need (CON) Regulation, 2007. Even privately owned hospitals 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.⁸⁰ Most states prevent new hospitals from opening by effectively giving incumbent hospitals a veto through CON regulation. However, this does not reduce health spending but rather leads to higher prices and suffering communities in need of health services.

Of course, not all states’ CON regulations are equally harmful. CON regulations are often very complex: a state might require a CON for only 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, originally reported in the first edition of *IHOP*.⁸¹ In order to update it, we reviewed CON legislation enacted in the states from 2006 through February 2008, as reported by the National Conference of State Legislatures.⁸² We identified 26 relevant bills enacted in 17 states, of which seven were positive, 10 negative, and nine neutral (on balance). We adjusted the previous rankings in accordance with these findings.

(Note: This is the only variable where the gradations are unequal, because Barnes assigned weights to different CON regulations.)

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.⁸³ However, there is little evidence that this opposition is socially beneficial, and there is evidence that patients would value such arrangements in many cases. For example, a retailer cannot open a health kiosk on its premises and hire physicians to staff the clinic if there is a ban on the corporate practice of medicine. By not allowing it, 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 in their physicians’ (inconvenient) offices.⁸⁴

Although organized medicine criticizes the corporate practice of medicine as an intrusion on doctors' freedom, restricting it is, in fact, an obstacle to both patients and physicians. Obviously, no physician would accept employment from a non-physician unless he thought it in his best interest to do so. Furthermore, 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 permitted in medicine are likely one factor in explaining why patients still access medical care much as they did four decades ago.⁸⁵

Regulations governing the corporate practice of medicine are complex. The Center to Advance Palliative Care originally surveyed state regulations concerning the corporate practice of medicine in 2003, sorting the states into five categories: those where the corporate practice of medicine is clearly forbidden, those where it is likely forbidden, those where the regulations are quite unclear, those where the corporate practice of medicine is unlikely to be forbidden, and those where it is definitely acceptable.⁸⁶ The first edition of IHOP used those rankings, favoring states with freedom to practice medicine on a corporate model. The Center to Advance Palliative Care issued an update in September, 2006, but it did not include a similar table.⁸⁷ Our review of the latter publication led us to re-grade six states when we replicated the table.

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.⁸⁸ Remarkably, some states restrict the freedom of patients and doctors to communicate across state lines. As with the corporate practice of medicine, regulations governing telemedicine are complex.

The first edition of IHOP developed eight gradations from an analysis produced by the Center for Telemedicine Law (now the Center for Telehealth & E-Health Law) in 2003.⁸⁹ The first three gradations concern whether rules governing telemedicine are imposed via legislation, regulation, or other policy. The other five concern whether the out-of-state doctor needs to be licensed in the patient's state—specifically for telemedicine or generally—and 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.

In order to update the gradations, we synthesized information from four sources that address recent developments in telemedicine legislation and regulation: a 2006 publication of Healthcare Licensing Services, Inc., a 2007 publication of MedLicense.com, a 2008 publication of the American Medical Association, and a 2007 publication of the Center for Telehealth & E-Health Law.⁹⁰

23. Nurse Practitioner Prescribing Autonomy, 2008. 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 comes 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, between June 2004 and May 2005, consumer-directed health plan enrollees were twice as likely to visit such a clinic as patients in traditional health plans.⁹¹ Unfortunately, rules restricting nurse practitioners inhibit this innovation.

In California, for example, one physician must directly supervise no more than four nurse practitioners. Convenience clinics tend to be staffed by nurse practitioners, so this type of regulation renders them uneconomical.⁹² 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.⁹³

IHOP incorporates two measures of nurse practitioners’ scope of practice, both from the *Nurse Practitioner’s Business Practice and Legal Guide*, a standard text written by an attorney who is herself a nurse practitioner. The first edition of IHOP used the 2004 edition. This one uses the 2008 edition.⁹⁴ The *Guide* measures nurse practitioners’ prescribing authority on five gradations:

1. explicit legal authority to prescribe, with no physician involvement required;
2. explicit legal authority to prescribe, but physician must review a percentage of nurse practitioner’s charts as part of a quality assurance plan;
3. authority to “furnish” drugs, with physician’s delegation;
4. authority to prescribe, with physician’s delegation under protocols;
5. explicit legal authority to prescribe, but with physician collaboration required.

Most states rank low, legally requiring a physician to “collaborate” with the nurse practitioner. The highest score goes to states that give nurse practitioners explicit authority to prescribe independently.

24. Nurse Practitioner–Physician Relationship, 2008. This variable addresses the issue noted above for California. It includes nine gradations, from physician collaboration to supervision, using the same source as variable 23.⁹⁵

(Note: This is the only variable where there are “empty” gradations, and a large “space” between one state and all the others. This is because Michigan has no scope of practice defined for nurse practitioners at all. It is as if, in the measurement of burden of facility CON regulation, number 20, there was a state with no health facilities at all!)

OVERALL RESULTS

Table 3: U.S. Index of Health Ownership Overall Ranking					
Rank	State	Score	Rank	State	Score
1	Alabama	19.27974	26	Washington	25.78435
2	Montana	19.33079	27	Hawaii	25.81955
3	Nebraska	20.35068	28	Arkansas	25.95150
4	North Dakota	20.50824	29	Texas	26.02036
5	New Hampshire	20.86575	30	South Carolina	26.11859
6	Idaho	20.89640	31	Maryland	26.20963
7	Utah	21.60303	32	Alaska	26.27889
8	Kansas	21.67472	33	Oregon	26.39329
9	Missouri	21.90292	34	Georgia	26.78107
10	Louisiana	22.20333	35	Illinois	26.81375
11	Tennessee	22.28460	36	Maine	26.89705
12	Indiana	22.83962	37	Pennsylvania	26.93750
13	South Dakota	22.89366	38	Minnesota	26.98684
14	Iowa	23.06170	39	Arizona	27.14081
15	Delaware	23.15334	40	West Virginia	27.36006
16	Mississippi	23.22413	41	Wyoming	27.37144
17	Nevada	23.36618	42	Ohio	28.25445
18	Michigan	23.50764	43	Connecticut	28.54905
19	Wisconsin	24.01743	44	California	29.71733
20	Florida	24.46144	45	New Jersey	30.37106
21	Colorado	24.67301	46	North Carolina	30.58054
22	Virginia	24.90662	47	Vermont	30.64373
23	New Mexico	24.92746	48	Rhode Island	31.43953
24	Kentucky	25.23120	49	Massachusetts	33.13326
25	Oklahoma	25.69126	50	New York	36.49692

Chapter 3: Results

The Top Five: Alabama, Montana, Nebraska, North Dakota, and New Hampshire

- **Alabama** leads the pack, primarily because of a lightly regulated private insurance market, and good control of state government programs. Also, the state performs well on medical tort indicators. Alabama's regulatory environment for providers favors competition, and government health programs run more effectively than in most other states. The only category where Alabama falls in the bottom half of the rankings is provider burden of regulation, because of too much government ownership of hospitals and overregulation of the scope of practice of nurse practitioners.
- **Montana** is 2nd, primarily because of its light regulation of providers. In all three other categories, it falls in the top half. Its only outstanding negative is the large medical malpractice loss ratio.
- **Nebraska** is 3rd, performing very well on regulation of private health insurance, medical tort, and the burden of regulation on providers. It just misses the top half of the rankings for government health care programs, because of a poor record of innovation in exploiting Medicaid waivers, and excessive eagerness to enroll its residents in government health programs.
- **North Dakota** is 4th, primarily because of lightly regulated private health insurance and competitive provider markets. It does somewhat less well at limiting its government health programs and only middling on medical tort.
- **New Hampshire** is 5th, because of a great performance in provider burden of regulation and medical tort. With respect to regulation of private insurance and government health care programs, the state performs significantly worse.

The Bottom Five: New York, Massachusetts, Rhode Island, Vermont, and North Carolina

- **New York**, at the bottom of the list, suffers from government health programs that are out of control, a grossly overregulated private insurance market, and almost completely uncompetitive provider markets. It also lies deep near the bottom of the medical tort rankings. However, it scores well on some variables within these categories.
- **Massachusetts** is 49th, with almost exactly the same negative characteristics as New York. However, it lies in the middle of the pack of medical tort rankings.
- **Rhode Island** is 48th, suffering from uncompetitive provider markets and a poor medical tort environment. However, it achieves middling performance on government health programs and actually does quite well on provider burden of regulation.
- **Vermont** is 47th, with a terrible medical tort environment and overregulation of private health insurance. However, Vermont sits in the middle of the pack in the other two categories, government health programs and provider burden of regulation.
- **North Carolina** is 46th. 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 lies in the top half of the rankings on some individual variables.

GOVERNMENT HEALTH CARE CATEGORY RESULTS

Table 4: Ordinal Ranking of State-Government Health Care					
Rank	State	Score	Rank	State	Score
1	South Dakota	14.91667	26	Pennsylvania	25.25000
2	Tennessee	16.58333	27	Nebraska	25.41667
3	Colorado	16.66667	27	Connecticut	25.41667
4	Alabama	17.41667	29	Hawaii	26.00000
5	Kansas	18.16667	30	North Dakota	26.16667
5	West Virginia	18.16667	31	New Hampshire	26.50000
7	Florida	18.25000	31	Rhode Island	26.50000
7	Kentucky	18.50000	33	Oregon	26.75000
9	Iowa	18.66667	33	Wyoming	26.75000
10	Missouri	19.25000	35	Arkansas	27.00000
10	Virginia	19.25000	36	Utah	27.16667
12	Delaware	19.41667	37	Idaho	27.91667
13	Montana	19.58333	37	North Carolina	27.91667
14	Louisiana	19.83333	39	Georgia	29.25000
15	Texas	20.41667	40	Maine	29.41667
16	Nevada	20.83333	41	Oklahoma	30.75000
17	Mississippi	21.16667	42	Arizona	32.41667
18	New Jersey	22.08333	43	Ohio	34.33333
19	Michigan	22.16667	44	New York	35.00000
20	Washington	23.33333	45	California	36.00000
21	Maryland	24.00000	46	Illinois	36.50000
22	Indiana	24.50000	47	New Mexico	37.58333
23	Vermont	24.75000	48	Massachusetts	38.00000
24	Wisconsin	25.16667	49	Minnesota	40.16667
24	South Carolina	25.16667	50	Alaska	42.58333

The Top Five: South Dakota, Tennessee, Colorado, Alabama, and Kansas

- **South Dakota** leads, performing very well at enrolling Medicaid beneficiaries in managed care and avoiding dependency on federal matching funds.
- **Tennessee** is 2nd, investing in pharmaceutical spending and enrolling its Medicaid beneficiaries in managed care plans. However, we should note that Tennessee had a disastrous experience with its government health programs a few years ago, so some of its indicators may be measured from a very low baseline.
- **Colorado** is 3rd, performing well on Medicaid managed care enrollment, while limiting SCHIP enrollment.
- **Alabama** places 4th, with severely limited Medicaid eligibility and correspondingly low federal matching funds.
- **Kansas** is 5th, with similar characteristics to Alabama, plus limiting SCHIP enrollment.

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

- **Alaska** trails the pack. It does terribly with respect to failing to enroll Medicaid beneficiaries in managed care, taking more than its “fair” share of federal matching funds, and not investing in prescriptions for its Medicaid population.
- **Minnesota**, 49th, suffers from extremely high Medicaid eligibility, poor innovation through waivers, freeloading on federal taxpayers, and inadequate investment in prescription drugs.
- **Massachusetts**, 48th, is dragged down by out-of-control SCHIP enrollment and underinvestment in prescriptions.
- **New Mexico**, at 47th, seriously underinvests in prescription drugs, is much too dependent on federal matching payments, and has overexpanded Medicaid eligibility.
- **Illinois**, at 46th, does very poorly with respect to Medicaid innovation through waivers and enrolling beneficiaries in managed care, and it brings too many kids into government health care.

The Top Five: Iowa, North Dakota, Alabama, Idaho, and Nebraska

- [Iowa](#), the leader, enjoys extremely low premiums for both individual and small group markets, has few uninsured, and the burden of mandates is light.
- [North Dakota](#), 2nd, enjoys a very low burden of regulation, and low premiums for both individual and small group markets.
- [Alabama](#), 3rd, has a very light burden of both regulation and mandates.
- [Idaho](#), 4th, enjoys very low individual premiums, has very light mandates, and is relatively free of regulation.
- [Nebraska](#), 5th, leads with respect to the burden of regulation and performs well in all other indicators in this category.

The Bottom Five: New York, New Jersey, Massachusetts, Maine, and Rhode Island

- [New York](#), in last place, does poorly in every area, especially its premiums and management of its high-risk pool (or lack thereof).
- [New Jersey](#), 49th, has almost exactly the same profile as its neighbor, but with a less heavy burden of regulation.
- [Massachusetts](#), 48th, suffers from bad scores for the burden of regulation, high premiums, and a weak high-risk pool.
- [Maine](#), 47th, also has very high premiums, suffers from overregulation, and fails badly in the high-risk pool variable.
- [Rhode Island](#), 46th, has high premiums and performs badly with respect to the high-risk pool.

MEDICAL TORT CATEGORY RESULTS

Table 6: Ordinal Ranking of State Medical Tort					
Rank	State	Score	Rank	State	Score
1	Nevada	10.60000	26	Virginia	26.79167
2	Louisiana	16.45833	27	Maine	27.04167
3	Michigan	16.88333	28	Kansas	27.29167
4	New Hampshire	17.02500	29	Tennessee	27.35833
5	Alaska	17.49167	30	Arizona	28.21667
6	Georgia	19.66667	31	Arkansas	28.79167
7	Idaho	20.65000	32	Utah	29.03333
8	Indiana	20.97500	33	New Jersey	29.65000
9	Alabama	21.37500	34	North Carolina	29.66667
10	Nebraska	21.44167	35	Connecticut	29.78333
11	Mississippi	21.60000	36	West Virginia	30.78333
12	Minnesota	21.94167	37	Hawaii	32.16667
13	Florida	22.21667	38	Maryland	32.37500
14	Illinois	22.59167	39	Wisconsin	33.20833
15	Montana	22.62500	40	Ohio	33.65833
16	California	22.79167	41	Washington	33.74167
17	Oklahoma	23.39167	42	Oregon	33.79167
18	South Carolina	24.49167	43	South Dakota	34.00833
19	Texas	24.79167	44	Wyoming	34.20833
20	Missouri	24.99167	45	Kentucky	35.47500
21	North Dakota	25.00833	46	New York	36.40833
22	Colorado	25.30000	47	Vermont	36.52500
23	New Mexico	25.64167	48	Iowa	37.15000
24	Delaware	26.15833	49	Pennsylvania	37.45833
25	Massachusetts	26.73333	50	Rhode Island	41.48333

The Top Five: Nevada, Louisiana, Michigan, New Hampshire, and Alaska

- [Nevada](#) takes first place, mostly because of caps on damages and a low medical malpractice loss ratio.
- [Louisiana](#), 2nd, caps damages, has a good statute of limitations, and imposes conditions on the use of expert witnesses; in fact, it does well in all variables in this category except limiting attorney fees.
- [Michigan](#), 3rd, does well by capping damage awards, imposing conditions on the use of expert witnesses, and achieving a relatively low loss ratio.
- [New Hampshire](#), 4th, succeeds especially through limiting attorney fees and requiring pre-trial screening or arbitration.
- [Alaska](#), 5th, imposes conditions on the use of expert witnesses and requires pre-trial screening or arbitration, while enjoying a very good medical malpractice loss ratio.

The Bottom Five: Rhode Island, Pennsylvania, Iowa, Vermont, and New York

- [Rhode Island](#) comes in last, doing especially poorly with respect to limiting attorney fees and capping damages.
- [Pennsylvania](#), 49th, performs worst on imposing conditions on the use of expert witnesses and limiting attorney fees.
- [Iowa](#), 48th, does extremely poorly in the areas of attorney fee limits and capping medical malpractice damages.
- [Vermont](#), 47th, does poorly in capping damages, limiting attorney fees, and imposing conditions on the use of expert witnesses.
- [New York](#), 46th, suffers from a high medical malpractice loss ratio, and also lies at the bottom of the rankings for attorney fee limits and imposing conditions on the use of expert witnesses.

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	8.00000	26	Oklahoma	26.66127
2	New Hampshire	12.66529	27	Vermont	26.70902
3	Montana	13.81181	28	Alabama	27.01667
4	Maine	13.87227	29	Virginia	27.34241
5	Utah	17.50000	30	Texas	27.72917
6	Oregon	19.03148	31	Illinois	28.02695
7	Pennsylvania	19.79167	32	Indiana	28.14863
8	Washington	19.81239	33	Kansas	28.18750
9	North Dakota	20.22917	34	Florida	28.45485
10	Delaware	20.75047	35	California	28.81250
11	Alaska	21.56329	36	Mississippi	28.86469
12	Rhode Island	21.65358	37	Hawaii	28.96760
13	Louisiana	22.15802	38	Colorado	29.10417
14	Nebraska	22.32469	39	Arkansas	29.28704
15	Tennessee	22.36342	40	Connecticut	29.45833
16	Ohio	22.54128	41	Massachusetts	29.45880
17	Idaho	23.54167	42	Iowa	29.87709
18	South Dakota	23.85417	43	Nevada	30.20563
19	Arizona	24.77083	44	New Jersey	30.39484
20	Minnesota	24.85417	45	Georgia	31.97276
21	Wyoming	24.98196	46	New York	32.40510
22	Wisconsin	25.46744	47	West Virginia	33.39934
23	Missouri	25.48365	48	North Carolina	34.01915
24	Maryland	25.58473	49	Michigan	36.81390
25	Kentucky	25.90433	50	South Carolina	37.00541

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

- [New Mexico](#) takes this category through having few restrictions on nurse practitioners' scope of practice and the corporate practice of medicine, and no CON regulations.
- [New Hampshire](#), 2nd, does very well with respect to nurse practitioners and a very small share of government-owned hospitals.
- [Montana](#), 3rd, is not outstanding in any single variable, but scores in the top half of all of them.
- [Maine](#), 4th, enjoys an idiosyncratically high showing through giving freedom to nurse practitioners and allowing the corporate practice of medicine.
- [Utah](#), 5th, has no CON regulations and allows the corporate practice of medicine.

The Bottom Five: South Carolina, Michigan, North Carolina, West Virginia, and New York

- [South Carolina](#), in last place, lies well in the bottom half of all variables except the nurse practitioner–physician relationship.
- [Michigan](#), 49th, turns the tables on its good performance in medical tort by landing in the bottom half of all the variables in this category, except the share of hospitals owned by government.
- [North Carolina](#), 48th, is also well in the bottom half of all variables except the nurse practitioner–physician relationship.
- [West Virginia](#), 47th, performs in the bottom half of all indicators except government ownership of hospitals and the nurse practitioner–physician relationship.
- [New York](#), 46th, is especially burdened by overregulation of nurse practitioners and the corporate practice of medicine.

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, Alabama, scores 18 when the best possible score is 1, and no state is outstanding in all categories or variables. Each state can learn from its fellows what it needs to improve in order 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 this author, and PRI, that we will be able to repeat this exercise on a regular basis. This will give concerned citizens who think otherwise a good basis to demand from their politicians market-oriented reforms that will result in more health ownership and freedom from government control of their health choices.

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Endnotes

- ¹ Harris Interactive, *Oil, Pharmaceutical, Health Insurance, Managed Care, Utilities and Tobacco Top the List of Industries That Many People Think Need More Regulation*, Harris Poll #78 (Rochester, NY: Harris Interactive, October 24, 2006).
- ² Christopher J. Conover, *Health Care Regulation: A \$169 Billion Hidden Tax*, Policy Analysis No. 527 (Washington, D.C.: Cato Institute, October 4, 2006).
- ³ James R. Copland et al., *What States Can Do to Reform Health Care: A Free Market Primer*, John R. Graham, ed. (San Francisco: Pacific Research Institute, July 2006).
- ⁴ James C. Robinson, *The Corporate Practice of Medicine* (Berkeley: University of California Press, 1999).
- ⁵ J. D. Kleinke, *Oxymorons: The Myth of a U.S. Health Care System* (San Francisco: Jossey-Bass, 2001).
- ⁶ Harris Interactive, *Oil, Pharmaceutical, Health Insurance, . . .*, Harris Poll #78.
- ⁷ Conover, *Health Care Regulation*.
- ⁸ Ibid.
- ⁹ See, e.g., Jane S. Shaw, “Public Choice Theory,” *The Concise Encyclopedia of Economics*, David R. Henderson, ed. (Indianapolis: Liberty Fund, 2002).
- ¹⁰ James Gwartney et al., *Economic Freedom of the World: 2007 Annual Report* (Vancouver, BC: Fraser Institute, 2007), p. 7.
- ¹¹ Ibid., pp. 195–204.
- ¹² Kim R. Holmes et al., *2008 Index of Economic Freedom* (Washington, D.C.: Heritage Foundation, 2008).
- ¹³ John D. Byars, Robert McCormick, and Bruce Yandle, *Economic Freedom in America’s 50 States: A 1999 Analysis* (Clemson, SC: Clemson University, Department of Economics, March 1, 1999).
- ¹⁴ Michael Walker, Dexter Samida, and Faisal Arman, *Provincial Economic Freedom in Canada, 1981–1998*, Critical Issues Bulletin (Vancouver, BC: Fraser Institute, January 1999); and Amela Karabegovi and Fred McMahon, with Christy G. Black, *Economic Freedom of North America 2006 Annual Report*, Digital Publication (Vancouver, BC: Fraser Institute, September 26, 2006).
- ¹⁵ Ying Huang, Robert E. McCormick, and Lawrence J. McQuillan, *U.S. Economic Freedom Index: 2004 Report* (San Francisco, CA: Pacific Research Institute, November 16, 2004).
- ¹⁶ Lawrence J. McQuillan and Hovannes Abramyan, *U.S. Tort Liability Index: 2008 Report* (San Francisco: Pacific Research Institute, 2008), pp. 50–56.
- ¹⁷ William W. Beach, *The 2006 Index of Dependency*, Center for Data Analysis Report #06-11 (Washington, D.C.: Heritage Foundation, December 1, 2006), p. 1.
- ¹⁸ John R. Graham, “Taming the Medicaid Monster: The President Pushes Progress but the States Shirk Solutions,” *Health Policy Prescriptions*, Vol. 4, No. 8 (August 2006); and John R. Graham, “How Many Governors Does It Take to Reform Medicaid?” *Health Policy Prescriptions*, Vol. 3, No. 1 (August 2005).
- ¹⁹ Rexford E. Santerre, “The state of health care, in one easy number,” *New York Times*, December 1, 2003.
- ²⁰ John R. Graham, “Ranking Health Care in the States: What Matters?” *Health Policy Prescriptions*, Vol. 5, No. 7 (July 2007).
- ²¹ Nadeem Esmail and Michael Walker, *How Good Is Canadian Health Care? An International Comparison of Health Care Systems, 2007 Report*, Digital Publication (Vancouver, BC: Fraser Institute, 2007).
- ²² I have criticized this bill in an earlier paper: John R. Graham, *Deadly Solution: SB-840 and the Government Takeover of California Health Care* (San Francisco: Pacific Research Institute, June 12, 2006).
- ²³ Health Consumer Powerhouse, *Vårdkonsumentsindex 2006* (Stockholm and Brussels: Health Consumer Powerhouse, May 2006).
- ²⁴ Health Consumer Powerhouse, *Euro Health Consumer Index 2007* (Stockholm and Brussels: Health Consumer Powerhouse, October 1, 2007).
- ²⁵ Health Consumer Powerhouse AB and Frontier Center for Public Policy, *Euro-Canada Health Consumer Index 2008*, FC Policy Series No. 38 (Stockholm and Brussels: Health Consumer Powerhouse; and Winnipeg: Frontier Center for Public Policy, January 21, 2008), p. 2.
- ²⁶ John R. Graham and Tanya Tabler, *Canadian Pharmacare: Performance, Incentives, and Insurance*, Digital Publication (Vancouver, BC: Fraser Institute, March 15, 2005).
- ²⁷ This is another example where measurement appropriate in another nation’s context would not be appropriate in the United States. I would certainly not recommend the U.S. federal or state governments’ underwriting catastrophic health insurance, because we have private health insurers that can fulfill that function, whereas they are still illegal in Canada.

- ²⁸ United Health Foundation, *America's Health Rankings: 2007 Edition* (Minnetonka: United Health Foundation, November 5, 2007).
- ²⁹ Lawrence J. McQuillan and Hovannes Abramyan, *U.S. Tort Liability Index: 2006 Report* (San Francisco: Pacific Research Institute, May 11, 2006).
- ³⁰ In this case, if there is a tie for 5th place, for example, both are given 5.5 and the next state is given 7.
- ³¹ McQuillan and Abramyan, *U.S. Tort Liability Index: 2006 Report*, p. 32.
- ³² Copland et al., *What States Can Do to Reform Health Care*.
- ³³ Nina Owcharenko, "Options and Opportunities for State Medicaid Reform," *What States Can Do to Reform Health Care*, pp. 5–19; Graham, "Taming the Medicaid Monster"; and Graham, "How Many Governors Does It Take to Reform Medicaid?"
- ³⁴ Graham, "Taming the Medicaid Monster"; and Graham, "How Many Governors Does It Take to Reform Medicaid?"
- ³⁵ Centers for Medicare & Medicaid Services, *Medicaid State Waiver Program Demonstration Projects—General Information* (Baltimore: Centers for Medicare & Medicaid Services, 2006). Available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/>.
- ³⁶ CMS, *Medicaid Waivers and Demonstrations List* (Baltimore: Centers for Medicare & Medicaid Services, June 24, 2008), available at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>.
- ³⁷ CMS, *Health Expenditures by State of Residence: Medicaid Summary Tables, 1991–2004* (Baltimore: Centers for Medicare & Medicaid Services, September 2007), available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-mcaid.pdf>.
- ³⁸ John R. Graham, "Squeezing the Balloon: The Futility of Pharmaceutical Cost Containment," *What States Can Do to Reform Health Care*, pp. 99–113.
- ³⁹ Linda Gorman, *Medicaid Drug Formularies: Do They Perform as Advertised?* Issue Paper No. 2-2002 (Boulder: Independence Institute, November 5, 2002).
- ⁴⁰ Kaiser Family Foundation, *Statehealthfacts.org, Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of June 30, 2006* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), available at <http://www.statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4>.
- ⁴¹ David Gratzner, *The Cure: How Capitalism Can Save American Health Care* (New York: Encounter Books, 2006), p. 107.
- ⁴² CMS, *2004 Medicaid Managed Care Enrollment Report* (Baltimore: Centers for Medicare & Medicaid Services, 2004), p. 3; CMS, *2005 Medicaid Managed Care Enrollment Report* (Baltimore: Centers for Medicare & Medicaid Services, 2005), p. 1; and Kaiser Family Foundation, *Medicaid Managed Care Enrollees*.
- ⁴³ Peter J. Cunningham and Jessica H. May, *Medicaid Patients Increasingly Concentrated among Physicians*, Tracking Report No. 16 (Washington, D.C.: Center for Studying Health System Change, August 2006).
- ⁴⁴ John C. Goodman et al., *Opportunities for State Medicaid Reform*, NCPA Policy Report No. 288 (Dallas: National Center for Policy Analysis, September 2006), p. 23. For anecdotes complaining about restrictions in managed care, see Barbara Martinez, "In Medicaid, Private HMOs Take a Big, and Profitable Role," *Wall Street Journal*, November 15, 2006, p. A1.
- ⁴⁵ Laurence C. Baker and Christopher Afendulis, "Medicaid Managed Care and Health Care for Children," *Health Services Research*, Vol. 40, No. 5 (October 2005), pp. 1466–1488.
- ⁴⁶ Andrew B. Bindman et al., "The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions," *Health Services Research*, Vol. 40, No. 1 (February 2005), pp. 19–37; Stephen Zuckerman, "Has Medicaid Managed Care Affected Beneficiary Access and Use?" *Inquiry*, Vol. 39, No. 3 (Fall 2002), pp. 221–242; Moira Inkelas, "Incentives in a Medicaid Carve-Out," *Health Services Research*, Vol. 40, No. 1 (February 2005), pp. 79–99; Embry M. Howell et al., "The Impact of Medicaid Managed Care on Pregnant Women in Ohio: A Cohort Analysis," *Health Services Research*, Vol. 39, No. 4, Part 1 (August 2004), pp. 825–846.
- ⁴⁷ Robert Kaestner, Lisa Dubay, and Genevieve Kenney, *Medicaid Managed Care and Infant Health: A National Evaluation*, NBER Working Paper No. 8936 (Cambridge, MA: National Bureau of Economic Research, 2002), showed no difference between traditional and managed care Medicaid models. Bowen Garrett, Amy J. Davidoff, and Alshadye Yemane, "Effects of Medicaid Managed Care Programs on Health Services Access and Use," *Health Services Research*, Vol. 38, No. 2 (April 2003), pp. 575–594, suggests better outcomes for children and worse for women. Jayasree Basu, Bernard Friedman, and Helen Burstin, "Managed Care and Preventable Hospitalization among Medicaid Adults," *Health Services Research*, Vol. 39, No. 3 (June 2004), pp. 489–509, suggests that managed care's effects are positive in the private market but not in Medicaid. Janet Currie and John Fahr, *Medicaid Managed Care: Effects on Children's Medicaid Coverage and Utilization*, NBER Working Paper No. 8812 (Cambridge, MA: National Bureau of Economic Research, 2002), and Thomas C. Buchmueller, Todd Gilmer, and Katherine Harris, "Health Plan Disenrollment in a Choice-Based Medicaid Managed Care Program," *Inquiry*, Vol. 41, No. 4 (Winter 2004–2005), pp. 447–460, both suggest that superior Medicaid managed care performance for children is associated with "cream skimming" by race. Mark Duggan, *Does Contracting Out Increase the Efficiency of Government Programs? Evidence from Medicaid HMOs*, NBER Working Paper No. 9091 (Cambridge, MA: National Bureau of Economic Research, 2002), concludes from California data that Medicaid managed care increased costs but not quality.
- ⁴⁸ Graham, "Taming the Medicaid Monster."
- ⁴⁹ *Ibid.* See also Graham, "How Many Governors Does It Take to Reform Medicaid?"

- ⁵⁰ Goodman et al., Opportunities for State Medicaid Reform, pp. 51–54.
- ⁵¹ CMS, *Health Expenditures by State of Residence, 1991–2004*, compressed (zipped) folder (Baltimore: Centers for Medicare & Medicaid Services, September 2007), available at http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp#TopOfPage. To be clear: we did not estimate new coefficients by replicating CMS’ regression analysis with new data, but used their coefficients to generate new estimates to compare with actual spending in 2004. The difference from their original outcomes verged on trivial.
- ⁵² Graham, “Taming the Medicaid Monster”; and Graham, “How Many Governors Does It Take to Reform Medicaid?”
- ⁵³ Kaiser Family Foundation, *Statehealthfacts.org* (Menlo Park, CA: Henry J. Kaiser Family Foundation, January 2008), available at www.statehealthfacts.org.
- ⁵⁴ Kaiser Family Foundation, *Statehealthfacts.org, Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL)*, 2008 (Menlo Park, CA: Henry J. Kaiser Family Foundation, January 2008), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4>; *Statehealthfacts.org, Income Eligibility Levels for Pregnant Women under Medicaid or SCHIP by Annual Income and as a Percent of Federal Poverty Level (FPL)*, 2008 (Menlo Park, CA: Henry J. Kaiser Family Foundation, January 2008), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=206&cat=4>; and *Statehealthfacts.org, Income Eligibility Levels for Children’s Regular Medicaid and Children’s SCHIP-Funded Medicaid Expansions by Annual Income and as a Percent of Federal Poverty Level (FPL)*, 2008 (Menlo Park, CA: Henry J. Kaiser Family Foundation, January 2008), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=203&cat=4>.
- ⁵⁵ J. P. Wieske, “Health-Insurance Reform in the States: Two Steps Backward in Some States, One Step Forward in Others,” *What States Can Do to Reform Health Care*, pp. 21–35.
- ⁵⁶ Merrill Matthews, J. P. Wieske, and Victoria Craig Bunce, *State Health Insurance Index 2006: A 50-State Comparison of the Nation’s Health Insurance Market* (Alexandria, VA: Council for Affordable Health Insurance, October 2006).
- ⁵⁷ Personal communication, J. P. Wieske, 2008.
- ⁵⁸ John R. Graham, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (San Francisco: Pacific Research Institute, 2008).
- ⁵⁹ Victoria Craig Bunce and J. P. Wieske, *Health Insurance Mandates in the States* (Alexandria, VA: Council for Affordable Health Insurance, 2008).
- ⁶⁰ Kaiser Family Foundation, *Statehealthfacts.org, Health Insurance Coverage of Nonelderly 0–64, States (2005–2006)*, U.S. (2006) (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2008), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=1268&cat=43>.
- ⁶¹ John R. Graham, *California’s Uninsured: Crisis, Conundrum, or Chronic Condition?* (San Francisco: Pacific Research Institute, 2006).
- ⁶² AHIP Center for Policy and Research, *Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: America’s Health Insurance Plans, December 2007), p. 9.
- ⁶³ Matthews, Wieske, and Bunce, *State Health Insurance Index 2006*.
- ⁶⁴ James R. Copland, “Malpractice Liability: Thoughtful Tort Reform Is Good Medicine,” *What States Can Do to Reform Health Care*, pp. 49–66.
- ⁶⁵ McQuillan and Abramyan, *U.S. Tort Liability Index, 2008 Report*, pp. 12–13.
- ⁶⁶ Daniel Kessler and Mark McClellan, “Do Doctors Practice Defensive Medicine?” *Quarterly Journal of Economics*, Vol. 111, No. 2 (May 1996), pp. 353–390.
- ⁶⁷ McQuillan and Abramyan, *U.S. Tort Liability Index, 2008 Report*, p. 27.
- ⁶⁸ *Ibid.*, p. 32.
- ⁶⁹ Daniel P. Kessler, William M. Sage, and David J. Becker, “Impact of Malpractice Reforms on the Supply of Physician Services,” *Journal of the American Medical Association*, Vol. 293, No. 21 (June 1, 2005), pp. 2618–2625.
- ⁷⁰ Walter K. Olson, “The Case against Expert Witnesses,” *Fortune* (September 25, 1989), pp. 133–138.
- ⁷¹ McQuillan and Abramyan, *U.S. Tort Liability Index, 2008 Report*, p. 37.
- ⁷² Claudia E. Lavenant, Craig L. Hayward, and Paul Jesilow, “Tort Reform and Physician Sanctioning,” *Law & Policy*, Vol. 24, No. 1 (January 2002), pp. 1–15.
- ⁷³ McQuillan and Abramyan, *U.S. Tort Liability Index, 2008 Report*, p. 32.
- ⁷⁴ *Ibid.*, p. 37.
- ⁷⁵ David M. Studdert et al., “Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment,” *Journal of the American Medical Association*, Vol. 293, No. 21 (June 1, 2005), pp. 2609–2617.
- ⁷⁶ Mark Schlesinger and Bradford H. Gray, “How Nonprofits Matter in American Medicine, and What to Do About It,” *Health Affairs*, Vol. 25, No. 4 (July/August 2006, published online June 20, 2006), pp. W287–W303.
- ⁷⁷ These issues are discussed very well in John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler, *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System* (Washington, D.C.: AEI Press, 2005).
- ⁷⁸ Martin Zelder, *How Private Hospital Competition Can Improve Canadian Health Care*, Public Policy Sources No. 35 (Vancouver, BC: Fraser Institute, 2000).

- ⁷⁹ Kaiser Family Foundation, *Statehealthfacts.org, Hospital Beds per 1,000 Population by Ownership Type, 2006*, available at <http://www.statehealthfacts.org/comparebar.jsp?ind=385&cat=8>. (Menlo Park, CA: Henry J. Kaiser Family Foundation, March 2008).
- ⁸⁰ Roy Cordato, "CON Game: It's Time to Repeal Hospital Certificate-of-Need Laws," *What States Can Do to Reform Health Care*, pp. 37–48.
- ⁸¹ John Barnes, *Failure of Government Central Planning: Washington's Medical Certificate of Need Program* (Seattle: Washington Policy Center, January 2006).
- ⁸² National Conference of State Legislatures, *2005–2006 Passed CON State Legislation and 2007–2008 Passed CON State Legislation* (Denver: National Conference of State Legislatures, February 25, 2008), available at <http://www.ncsl.org/programs/health/cert-need.htm#resources>.
- ⁸³ William B. Monning, *Report of the Organized Medical Staff Section Governing Council, Report BB I-05* (Chicago: American Medical Association, October 19, 2005).
- ⁸⁴ Devon Herrick, *Demand Growing for Corporate Practice of Medicine, NCPA Commentaries* (Dallas: National Center for Policy Analysis, January 1, 2006).
- ⁸⁵ *Ibid.*
- ⁸⁶ Center to Advance Palliative Care, *State Survey: Corporate Practice of Medicine* (New York: Center to Advance Palliative Care, November 2003).
- ⁸⁷ Mary H. Michal et al., *Corporate Practice of Medicine Doctrine: 50 State Survey Summary* (New York: Center to Advance Palliative Care, and Alexandria, VA: National Hospice and Palliative Care Organization, September 2006).
- ⁸⁸ Herrick, *Demand Growing for Corporate Practice of Medicine*.
- ⁸⁹ Center for Telemedicine Law, *Telemedicine Licensure Report*, prepared under contract #02-HAB-A215304 for the Office for the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services (Washington, D.C.: Center for Telemedicine Law, June 2003), pp. 13–14.
- ⁹⁰ Healthcare Licensing Services, *Multi-State Telemedicine Licensure* (Pensacola: Healthcare Licensing Services, June 2006), available at http://www.healthcarelicensing.com/Telemedicine_licensing.htm; MedLicense.com, *Telemedicine Licensure* (Columbus, GA: Medical Administrators of America, June 2007), available at http://www.medlicense.com/telemedicine_license.html; Janice Robertson, *Physician Licensure: An Update of Trends* (Chicago: American Medical Association, February 28, 2008), available at <http://www.ama-assn.org/ama/pub/category/2378.html>; and Center for Telehealth & E-Health Law, *Physician Licensure* (Washington, D.C.: Center for Telehealth & E-Health Law, 2007), available at <http://www.telehealthlawcenter.org/?c=155>.
- ⁹¹ "CDH, health plan partnerships help fuel dramatic growth of retail-based clinics," *Inside Consumer-Directed Health Care*, Vol. 4, No. 13 (Washington, D.C.: Atlantic Information Services, October 13, 2006).
- ⁹² Diana Ernst and John R. Graham, *Curing California Health Care: Five Steps towards Universal Choice in 2007* (San Francisco: Pacific Research Institute, January 2007).
- ⁹³ Shirley V. Svorny, "Physicians and Non-Physician Clinicians: Where Does Quality Assurance Come From?" *What States Can Do to Reform Health Care*, pp. 67–82.
- ⁹⁴ Carolyn Buppert, *Nurse Practitioner's Business Practice and Legal Guide*, 3rd edition (Boston: Jones & Bartlett, 2008), p. 198.
- ⁹⁵ *Ibid.*, p. 44.
- ⁹⁶ International Committee of Medical Journal Editors (ICMJE), *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* (Philadelphia: ICMJE Secretariat Office, American College of Physicians, February 2006). Available at www.icmje.org.

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"My role is to convene state lawmakers who share a common belief in limited government, free markets, federalism, and individual liberty. When I discuss the *U.S. Index of Health Ownership* with these legislators, it really opens their eyes to how states have violated these fundamental American principles, through over-legislating and over-regulating health care."

– **Christie Raniszewski Herrera**, director, Health and Human Services Task Force, American Legislative Exchange Council

