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Competition: A Prescription for Health Care Transformation

The Honorable Tom Coburn, M.D., Joseph Antos, Ph.D., and Grace-Marie Turner

STUART M. BUTLER, Ph.D.: Every so often, we are fortunate to have someone who comes to Washington, to the Congress, who really intends to make things happen. Senator Tom Coburn is clearly one of that rather rare breed of lawmaker who really comes with a mission, with a sense of urgency, and with a desire to bring about significant change. We've seen Senator Coburn in action over the last few months in the area of the budget, in looking at earmarks and forcing debate over some very tough issues. Not all his colleagues welcomed that discussion, but he has been determined in that area.

He's also been basically determined throughout his life. When he first started in the business world in the 1970s, he served as manufacturing manager at the Ophthalmic Division of Coburn Optical Industries in Virginia. Under his leadership, that division grew from 13 employees to over 350 and captured over a third of the U.S. market.

He came to Washington as a Member of Congress for Oklahoma's Second District between 1995 and 2001, and whilst in the House, he created a name for himself in many areas. Most recently, of course, he's come to the Senate, and he describes himself as a "citizen legislator" there, talking about a whole range of different issues and forcing debate on a whole set of questions, including the budget and, most recently, health care.

Indeed, on this last issue of health care, which has been very close to his concerns for many years as a doctor, we are privileged to have him speak to us today on

Talking Points

- America is going to have either a government-run health care system in which politicians and bureaucrats make the key decisions or a consumer-driven system in which key decisions are made by individuals and families.
- Physician and Senator Tom Coburn has introduced the Universal Health Care Choice and Access Act (S. 1019) to allow consumers to make their own health care decisions.
- Among the bill's provisions is prevention education to increase wellness and reduce health care costs. It contains a radical change to the tax code: a health care tax credit for all Americans and the ability for everyone to purchase health insurance from any qualified company in the country.
- Competition is critically important in health care as in every other facet of the economy. The bill allows a transparent health insurance industry to create programs that are best for individuals.

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/hl1030.cfm

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a proposal that tries to lay out a very different approach to health care in this country. The Universal Health Care Choice and Access Act (S. 1019) would radically change the system in a way that makes it a system that really works for the American people and provides a free-market–based system that would achieve our objectives in the health care area.[1]

—Stuart M. Butler, Ph.D., is Vice President for Domestic and Economic Policy Studies at The Heritage Foundation.

THE HONORABLE TOM COBURN, M.D.: If you go talk to people about their health care, you hear lots of things. Whether you talk to their employer or the somebody that is buying it, one of the basic tenets that you find is that we are having trouble affording the health care that we have. We spend greater than 16 percent of our GDP on health care—the highest of anybody in the world by 50 percent—and yet we are not 50 percent better. We are better, but barely better.

The second question that comes to mind is: Do we have the freedom with health care that we need to have in terms of being able to choose what is right for us, to choose those people who give us care, to be able to make the decisions about our health care? The same freedom that accompanies every other aspect of our society? The private sector, which is only about 55 percent of all our health care, has created the greatest set of innovations in health care that the world has ever known. About 75 percent of all health care innovations comes from this country. One of the reasons that this happens is the fact that we do have a private segment—although it is regulated. What we want to do is be sure to protect that private innovation in any health care reforms that we do.

We have 45 million people that do not have direct access to health insurance in this country. It is not accurate to say these 45 million people don't have health care; every hospital in America must accept and stabilize emergency patients, regardless of whether or not they are insured. What they do not have is a health insurance policy and *preventative* health care. We have not had an emphasis on prevention and wellness. If you look at our health care market and what is spent every year, 75 percent of the money we spend is spent on treating five diseases, of which the vast majority are preventable, and we can lessen the impact of those tremendously through prevention strategies.

In addition to emphasizing prevention, we must address the entitlements of Medicare and Medicaid. I would refer you to Comptroller General David Walker's Web site at the Government Accountability Office on the impending fiscal crisis that is facing our nation in the years to come because of these two entitlements. We have a train wreck coming, and the only way we can solve that is to fix our health care system so that it doesn't consume 16.2 percent of our GDP. People say, "Well, how can you do that?"

The first step is to allow market forces to improve quality for patients and hold costs in check. Nearly one of every three dollars spent on health care does not go toward helping anybody get well, and we ought to be questioning that.

How do we make health care more efficient? In our country, we have used competition and markets to allocate scarce resources, and we have done that very effectively in all but two areas of our economy. One is education, where there is a side debate going on about how we get competitive in education and raise the standards in education. The other is health care.

Health care is far more expensive to us, and the long-term consequences are great. A lot of people with private care—and even people in Medicare and Medicaid—do not have the privilege of choosing who is going to be their doctor. A lot of people do not have the opportunity to pick the health plan that is right for them; that decision is taken out of their hands, either by the government or by their employer.

The other questions are: Why do premiums go up every year at three times the rate of inflation in

1. For a detailed summary of Senator Coburn's proposal, the Universal Health Care Choice and Access Act, see *http://coburn.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=192cb546-c99e-4115-bb9f-6434dad2b700*.

this country, and yet the benefits that are associated with that increase in premiums don't rise? Why do we have such a confusing system where it is hard to figure out what you are buying and what you are getting? Why have we decided that Americans can get the tax benefit from health care only through their employers? And finally, who makes the best decisions about your own health care—you, your family, and your doctor or someone that you do not know?

The Choice Before Us: Government Control or a Free Market

In terms of the choices that are in front of us politically in today's environment, we are either going to have a government-run health care system or we are going to have a private, vigorous, healthy, consumer-oriented system where we actually allow market forces to allocate these scarce resources. We cannot afford what we are doing today.

On the one hand, if we have a government-run system, we might control the costs, but we will do that at great price. The way costs are restrained in every other government-controlled system is through rationing. What that means is that healthy people die earlier, people with disease do not get treatment on time, and the long-term consequence to a mobile and healthy society is that you lose productivity as people age.

All you have to do is look at the statistics, whether it is Britain or Canada or any other government-run system. For example, cancer patients in England have to wait too long for chemotherapy.[2] Think about what happens during that time: the potential benefit for a cure, the possibility for a cure.

So we have to make a decision in our country: Are we going to have the government making the choices that are rightly yours to make? Are we going to have the government running health care? Are we going to lose the innovation from a health care system that has produced 75 percent of the advances in health care that we have seen over the past 30 years, or are we going to go to something that we have proven in our society will allocate scarce resources, create great opportunity, advance quality, and give better price and better transparency?

My belief is that if the American people are given a choice, they will choose a market-oriented program. It fits with our culture, and it fits with our society. It's based on freedom; it's based on choice; it's based on decision-making; and it's based on accepting the consequences for the decisions you make.

Ensuring Access to Care

How do we go about doing that? The first thing is to make sure that everybody has access to care. Universal is usually a synonym for government-run health care, but we are not talking about that. We are talking about creating market incentives, creating incentives for states, and creating incentives for individuals so that everybody can get health care. The only government involvement is if somebody acts irresponsibly, in which case we allow a state to design and set up an enrollment mechanism for people who do not buy insurance.

Everyone in America could choose their own health insurance. You get to decide what is best for you and your family. You get to choose your own doctor.

Finally, we have an emphasis on prevention. If we don't start investing properly in prevention, we will never be able to afford treating the long-term health care consequences of not having that prevention base. Pfizer CEO Hank McKinnell, in his book,[3] outlined what is really happening in our society in terms of our health care. We have a health care system that is based on a chronic disease treatment model, and we need to have a health care system that's based on a prevention model.

How do we prevent illness, and how do we promote wellness? The federal government spends billions of dollars each year on prevention, and grandmother was right: "An ounce of prevention is worth a pound of cure." If you think about the five diseases I talked about—heart disease, stroke, chronic obstructive pulmonary disease, diabetes, and cancer—the vast majority of those diseases are

2. See Grace-Marie Turner and Robert E. Moffit, "European-Style Health Care? Time for a Reality Check," Galen Institute *Health Systems Abroad*, December 17, 2006, at *http://www.galen.org/healthabroad.asp?docID=950*.
3. See Hank McKinnell, *A Call to Action: Taking Back Healthcare for Future Generations* (New York: McGraw-Hill, 2005).

preventable or early-diagnosable to treat. Most diabetes cases today—type 2 diabetes—are preventable. We know what causes heart disease, how to diagnose it, how to prevent it, how to lower the risk. Hypertension leading to strokes, same thing, atherosclerotic vascular disease, hypertension associated with that. Chronic obstructive pulmonary disease, we know what causes it, and it is called tobacco.

So the first thing we do in our bill is prevention. We concentrate on effective prevention efforts through direct consumer knowledge. We set up a federal government Web site—there are some privately available—where everybody in the country can go on and look at your health risk factors and the things that ought to normally happen to you or be prescribed to you in terms of prevention strategies and screening strategies.

Additionally, the bill would redirect existing prevention dollars being spent on ineffective programs toward a health and wellness public marketing campaign. The power of advertising works for businesses, and it can work for prevention.

If Americans were to improve three lifestyle behaviors—regular exercise, proper nutrition, and smoking cessation—the results would decrease the morbidity of a multitude of diseases. For example, diet and exercise play a huge role in reducing the incidence of heart disease and diabetes. The vast majority of Americans do not know what they need to do, when they need to do it, or how they need to do it in terms of wellness and in terms of prevention. That message of prevention education to the American people will save us billions and billions of dollars.

For example, colon cancer can be cut in half through early screening and dietary changes. These are things we know, and yet this is the second-leading cause of death in men for cancer. Why would we not want to change that? Why would we not want to cut colon cancer in half? It is something we could easily do. It is something that is achievable within four or five years if we put the tools and the prevention strategies to work.

Changing the Tax Code

The second thing we do is change the tax code. This change is all on the employee side of the ledger. We do not do anything to employers; they still get to deduct whatever they buy for anybody in terms of health insurance. But we equalize the tax benefit for everybody in America in terms of where they get their health insurance.

Right now, if you're very wealthy in this country, the tax code gives you a benefit of about $2,700. If you're poor, you get a tax benefit of about $100. So what we do is equalize that, and we create a refundable tax rebate to everyone in America—$2,000 per person and $5,000 per family—that grows with the chain-weighted consumer price index each year. People say, "Well that's not enough." The average individual market policy in this country today—with all the mandates that are out there—costs $2,250. So with $250 of your own, you can have the average policy today. Anybody that's not covered today and that wants to be covered can get covered.

This does not take away your employer-provided insurance. While your health benefits are now a taxable part of your income—just like the rest of your wages—if your employer offers them, you will now have a tax credit that will offset those taxes. Rather than restricting that tax break to employer-sponsored insurance, you can use that tax credit to buy health insurance wherever you want to—the individual market, a Massachusetts-style connector, or your employer. The vast majority of Americans will benefit from this tax credit, either through families or through individuals.

With this comes individual choice in the health services market. What we tend to do is to look at the health insurance market the way it is today. We do not think about what it might be like if everybody was in the market, if the market was free to work, and how innovation could improve the market.

Key to free-market innovation is the ability to buy your insurance wherever you want to, from an insurance company incorporated in any state in America. Let us look at mandates and what they have done. If you compare the price of a health insurance policy in New Jersey, a heavily regulated state, with the price of one in a state like Kentucky, a more innovation-friendly state, you will see a sevenfold increase in cost for the same basic coverage from one state to the other.

So being able to buy your health insurance from wherever you want will cause innovation and lower prices in the health insurance market. There would still be a primary and a secondary state for licensing purposes, and there would still be oversight and consumer protections. A health insurance company could be incorporated in any state whose laws are most friendly to the development of innovative products, much as credit card companies have the freedom to do, and would have to meet solvency standards established by the National Association of Insurance Commissioners. So we are not going to see fly-by-night health insurance plans. We are going to see people that are truly insured and a true national market for individual health insurance.

Why is that important? Think about buying a car. If New Jersey required benefits on cars as it does for health insurance policies, you could not buy a car without GPS; you could not buy a car without a sunroof; you could not buy a car without seat warmers; you could not buy a car without a DVD that plays in the back seat; you could not buy a car that did not have remote control locks and unlocks; and you could not buy a car that didn't have OnStar. You could not buy a car that did not have all of that, and you probably would not buy a car there. It would be ridiculous to restrict you from traveling to another state like Kentucky, where you could buy whichever car you wanted.

The Universal Health Care Choice and Access Act would allow you to buy health insurance from wherever you want as well.

The Critical Importance of Competition

Critical to a national market for health insurance and true health care reform is the value of competition. All you have to do is take the Federal Employees Health Benefits Program system and look at how competition works there. We have 284 plans competing for federal employees' health insurance. While the majority of the country has experienced premium increases of 7.7 percent, premiums in the FEHBP increased by only 1.8 percent.[4]

Competition, as found in the FEHBP's design, will drive that. To truly allow competition and innovation to work, we need to deregulate health care. The bill allows a transparent health insurance industry to create programs that are best for individuals.

Let us say I have diabetes. I may want to buy a high-deductible policy that has a low-deductible component for my diabetes with a health insurance firm that wants to specialize in diabetic care. If we have great management in diabetes, we markedly decrease complications, and we markedly decrease hospitalization.

A good example of competition is Duke University, which set up a system where they managed congestive heart failure. What they did was markedly decrease the amount of trips to the hospital, markedly decrease hospitalization, markedly increase the life expectancy of the patients, and cut the costs by 32 percent because they specialized in that. It is not in existence today because of the way the reimbursement system is regulated in America—even though it was saving 32 percent and getting better patient outcomes.

What we know is that, if we can target prevention of chronic diseases and can remove barriers to innovation in the insurance market, competition and innovation work. We will see increased health, increased quality of life, and decreased cost in health care.

Reforming Medicaid

The next thing we do in this bill is Medicaid reform. If you look at the quality of care that Medicaid patients get versus the quality of care that other people get, it is not the same, even though we say we are giving care. The reason is that access is not the same, and one of the reasons the access is not the same is because the reimbursements are generally lower.

What we have done is create a two-tiered situation in Medicaid. What we have said is, "We are going to commit to give you care, but we are not going to give you quite the care of what everybody else in the country gets." We put a stamp on some-

4. See Robert E. Moffit, Ph.D., "Competition: Good for Your Health (Care)," Heritage Foundation *Commentary*, October 12, 2006, at *http://www.heritage.org/Press/Commentary/ed101206c.cfm*.

body's forehead and call them a Medicaid patient. All of a sudden their access is not the same because the reimbursement is not the same, the access to certain doctors is not the same, and the access to certain treatment is not the same. That is all because we have decided the bureaucrats are going to decide what you can have, when you can have it, and how much they are going to pay for it.

This plan gives states a budget and then allows the states to take their Medicaid money and take their disproportionate share hospital (DSH) money to create private insurance access for everybody that qualifies for Medicaid. If Medicaid patients choose to take advantage of a $2,000 tax rebate to buy a private insurance policy, their state can give them additional money to help buy the right policy for them.

Oklahoma has 600,000 people on Medicaid today. Add $2,000 to each one of those 600,000 people, and what does that do to Oklahoma's ability and motivation to buy a private insurance policy for everybody in the state of Oklahoma that is Medicaid-dependent?

Under the bill, we give states the flexibility, tools, and incentives they need to achieve universal access to health care. States have the benefit of flexibility and a defined Medicaid budget that rises annually based on the CPI. Individuals have a $2,000 tax rebate for the purchase of private health insurance. We then have a pool of bonuses for states that achieve universal health coverage; if a state gets to 95 percent coverage, it gets a monetary bonus. Everything we try to do in this bill is to incentivize the states to create a vibrant private insurance market and universal access for their citizens.

We also know that medical liability insurance now accounts for 10 percent of the costs of health care in the private sector. Administration and processing account for 6 percent; support and marketing, 5 percent; insurance industry profit, 3 percent; equipment, 5 percent; hospitals, 35 percent; doctors, 21 percent; prescription drugs, 15 percent.

If you could take that one-third of health care spending that is not spent directly on health care and squeeze it through the efficiency of competition, what would happen? We would not have to have more dollars in health care. What we would have is more dollars going toward true care rather than overhead. One out of every three claims that are filed in the private sector are claims against a deductible that has not been met. Why would we file a claim for a deductible that has not been met?

Independent Health Record Banks

The next thing we do is to create a charter for independent health record banks. What you will have in five or six years is a card, and on the card you will have your health insurance information, plus your deductible, plus your health savings account—or whatever account you may have if you do not have an HSA—plus your health or medical record. Wherever you go for health services, you provide your card. There is then an automatic update to your health record for whatever happens at that visit. Whenever you go the next time, your doctor or your caregiver does not have to flip through an old paper chart to find what happened at the last visit at the last doctor that you went to.

The vast majority of mistakes have come because, number one, we do not have the right medical history information and, number two, providers do not take the time to get it because it is so difficult to get. Payments for services are delayed because a claim for one service is never filed until it is time for all the claims in a medical practice to be filed.

Creating a charter for the private market to develop HIPAA-compliant independent health record banks will increase efficiency in medical recordkeeping and improve quality of care by reducing errors. Your information would be automated so that wherever you go in the country, wherever you walk in, your health record is available even if you do not have your card available to you. Health care providers could access your record with your permission and your PIN so that if you are in an emergency situation, your whole record can be seen and made available to anyone you authorize or your family authorizes to give your care. Some of the major health IT companies are already experimenting with this technology.

Addressing Dual Eligibility

The next area that we address is dual-eligibles, who are Medicare *and* Medicaid beneficiaries. We

create a Medicaid Advantage where we combine funding streams for both programs into a coordinated and efficient Medicaid Advantage program.

The average cost for a Medicare patient is about $10,600 per year. The average cost for a Medicaid/Medicare dual-eligible patient is about $22,000. When there are two payers and two sets of paperwork for one patient, we do not have a coordination of how somebody is actually caring for those dual-eligible, high-risk patients. We change that by giving states and seniors choice through Medicaid Advantage. Instead of a tug-of-war, one program is taking care of those individuals. Instead of two entities fighting against caring for those individuals, there is one local program caring for them.

The bill also addresses the legal costs associated with health care. Today, approximately 5 percent to 9 percent of health care spending has to do with liability. There is as much as $126 billion of tests ordered every year that patients don't need—absolutely don't need—but doctors and providers feel that they need. Now, $126 billion of $2.2 trillion is nearly 6 percent; if we could cut that in half, we could lower the cost of health care by 3 percent tomorrow.

Creating Health Courts

We incentivize states to create health courts that you can go to and get your claim heard. That claim would be heard by three doctors, three lawyers, and a judge with the court's own neutral health experts.

One of the things that happens in liability cases today is what is called "hired guns." You can get a doctor to testify about anything if you want them to, but it is not necessarily medically accurate. Today we get juries influenced not on the basis of the latest scientific data, not on the basis of the best practices that should be occurring in this country, but on how somebody can toy with an emotion—something that is very different from best practices.

The court is not mandatory; it is optional. Individuals can go there and get a determination. You can have a lawyer represent you there, or you do not have to have a lawyer represent you, but the medical facts of your case can be heard. If you do not like the outcome of the case, you can still go to a regular state court.

We do not step on the rights of state courts, but one of the ways we can decrease liability costs is to have facts out in the open. Once a case is heard by the health court, either party—plaintiff or defendant—can appeal and go straight to state court. They do not have to accept the findings, but whatever the health court's findings were, they would have to be admissible as evidence in a regular court. You should be able to look at a case and ask, "Was there a basis of negligence, and if there was, should there be compensation?" Then, if you don't like that decision, you can go on to court.

Native Americans and Veterans

Finally, if Native Americans, who supposedly have health care at Indian hospitals and government-run hospitals and clinics, do not think their service is adequate and do not think it's good, they can use a card to go wherever they want and buy private service. That does two things. Number one—this applies to veterans as well—it gives true access, keeping a commitment that the federal government has made. Number two, it makes those organizations—VA hospitals and Indian hospitals—have to compete, which improves their quality.

Everything we have done in this plan, including allowing the market to determine provider pricing and provider best practices, is to set up a consumer-driven, market-oriented health care system that allows individual choice, freedom, and liberty for the individuals in this country. This bill frees market forces to help us compete to where we lower the cost of health care.

I am convinced that if we had a true consumer-driven health care market today, we would in fact see health care costs 10 percent to 15 percent lower than they are today. We would also see disease incidence go down markedly; and, finally, we would see life expectancy improve dramatically in this country.

DR. BUTLER: Senator Coburn, as you might have expected, has taken a very broad, comprehensive approach to the whole area of health care and health care reform, and these proposals are enshrined in the Universal Health Care Choice and Access Act before the Congress. Senator Coburn will

probably have to leave for the Hill reasonably soon, so let's take a few questions specifically for Senator Coburn before we bring up the commentators.

QUESTION: I was on the Maryland Physician's Board for four years, in private practice the last year. An exceptionally wealthy attorney had disc surgery and lost his kidneys post-operatively, and I'm sure that you and I both know what happened: Dehydrated before surgery; not operated on until the end of the day. You then don't get enough fluid because no internist has to see you, and maybe a nurse practitioner or a PA doesn't really understand about profusing your kidneys. So he's been on dialysis three times a week for a year and a half.

This was at Georgetown. He then tells me that he was walking unsteadily, and he passed out. But he had a meeting in Texas with very wealthy, important clients, so he hired people to get him to Texas, take care of him there. He called the doctor when he got back, and his doctor said, "You probably had a stroke."

I submit to you that people don't want care; doctors have been so trashed that people feel they can do it all. While universal health is very, very good, if we got rid of the obesity, which is 60 percent of the population, and alcoholism, you could cut costs. But I submit to you that until we change the attitude toward health and toward physicians and get it out of being a business, an entrepreneurship, we are going to have money siphoned all over the place.

I appreciate your huge efforts, but the reality in the trenches is that you cannot get a neurosurgeon at Shady Grove Hospital for an emergency. Doctors are quitting. My friend was head of the Washington Cancer Institute for years; he quit. You're not going to have anybody to give you really good care anymore.

SENATOR COBURN: That is the very reason this bill is coming about. You just described better than I could the bleakness that is coming. The reason you cannot get a neurosurgeon is because of the liability.

QUESTION: No, it's because they get paid so little.

SENATOR COBURN: Your position, then, is that market forces will not have anything to do with the situation, that there would not be a price high enough to get a neurosurgeon to come to that hospital. I believe market forces will work, and I believe people will respond to market forces.

If you have had seven years of post-medical training as a neurosurgery resident, maybe your services might be a little more valuable than an ER doctor in an ER, and maybe, because we have a market-driven system, you might be compensated appropriately for your time. I believe in markets. America believes in markets. We have been successful because of that, and to say that markets will not work in health care—I do not believe that.

What is the other option? The other option is to have the government mandate and have quality continue to go down. The quality will not improve with a government-run health care system. All you have to do is look around the world and look at what the access problems are, and the delay in diagnosis and the delay in treatment.

Let me give you an example of why I think markets will work. There is a hospital in Toronto, Canada, that does nothing but hernia surgeries. Why do people go to Shouldice?

QUESTION: They're cherry picking.

SENATOR COBURN: I disagree that they are cherry picking. Anybody in the world can go there. The point is, that is one of the things we need to do. We are going to need specialization. You do not go to a surgeon to get your allergies treated. You go to somebody that is good at allergies. You do not go to a surgeon to get desensitization, endpoint titration for allergy treatment. You go to an allergist.

What the Shouldice Hospital has done is offer a procedure where they have a 98 percent satisfaction rate. They have an in-and-out procedure, and the cost is a third of what everybody around them charges, and it is because they are efficient at what they do. We ought to have more of that.

We have now gastroenterology clinics where you get a full colonoscopy, everything done, for $700. If you go into an outpatient surgery center or a hospital, it costs two or three times that. And the fact is that their performance is better. I believe that if we actually see specialization and competition based on that, we will see improved quality, not less.

QUESTION: That's how my neighbor ended up on dialysis.

SENATOR COBURN: No, your neighbor ended up on dialysis because the doctor who was taking care of him *did not* take care of him. He did not specialize, because most neurosurgeons would not let a patient go low in terms of fluid intravascular volume to surgery. Most would watch their urine output—yes, they would. You have less confidence in physicians than I do. I think most physicians are very well trained, want to do the right thing, and would have done the right thing.

The fact is that we have a system that is set up to say, "Let's see, I'm going to put you in the hospital, so I better have this doctor see you, this doctor see you, this doctor see you before I do something." The question is: Will a neurosurgeon take care of a patient, and are they trained to take care of them? Yes, they are. The question is: Why didn't they? And with the outcome data that are going to come, will you know who a good neurosurgeon is and who isn't? Yes, you will in a truly transparent and free market.

QUESTION: I have a question in regard to some of the things I project are likely to happen on Capitol Hill. How are you going to address the common concerns that get stated up there: that the only way something like this is going to work is if we have a "level playing field," that everybody offers a standard benefit package, and there are certain standards that apply, and unless you have a "level playing field" for insurers, you're going to have the issue that the doctor raised, which is cherry picking?

SENATOR COBURN: Right now, there is cherry picking in every market we have, and American consumers figure out how to get around that. The reason you have cherry picking in the health care system today is because we do not have consumers holding the system accountable. You do not have a market driving the system. What you have is a false market. You have the government driving it, and then you have large insurance farms that are driving it.

You talk about cherry picking. Every hospital in this country, if you walk in there without an insurance card, cherry-picks your billfold because they charge you two or three times what they charge anybody else that comes into that hospital. The system we have today promotes cherry picking.

A true market-driven system has transparency, both in terms of price and outcome. The American consumer is smart enough to assess value, assess quality, and assess price. We do it every day in everything that we do in this country, and to assume that individuals in this country cannot do it is insulting the intelligence of the American people.

So I believe a true market will win. Will it be perfect? No, but in follow-up to the previous lady's question, what is your solution? Do you want the government to just mandate suboptimal care for everybody? Do we want everybody to have socialized system–quality care in this country? Do we want everybody to have the same access that Medicaid patients have today? Who doesn't take the lower-paying patients today? It's the best doctors, the ones that have the best reputations. Why would they spend time getting $20 when they can get $100? They are not about to do that.

In some sectors of the health care market, there truly is a market, and it works. When the government says we are not going to compete in that system, that destroys innovation and access to the excellence of America's medical technology. I am saying let the consumer decide. Let the individual decide. Let us decide what is best for us—not Washington politicians. I guarantee you, it is like *Field of Dreams*: "If you build it, they will come."

No market is perfect, but what we have today is very far from perfect, and the very vulnerable people in our society, who we say we are helping, we are not helping. A market-driven system empowering those people to have choice and freedom in the quality of care and put them on a level of care that is equal to the highest CEO in this country is something our country ought to do.

QUESTION: You've made a convincing case that the government intrusion in the health care market is part of what's causing the problem, and I'm curious as to why part of your solution isn't to further scale back the intrusion that's already there. If you look back pre-1965, the level of char-

ity care in health care is considerably greater than what we have now, at a lower cost than what Medicaid is costing us, with better quality of care. What are you doing to encourage private charity care and scale back government intrusion from what it is now?

SENATOR COBURN: In essence, this plan creates charity care, because it says the very richest in this country will help contribute to a tax credit—instead of expanding a government program like Medicaid—for those that do not have the resources. What we do is put everybody on an equal footing, because everybody has access to an equal tax credit to buy private insurance under this bill. Everybody has access to a plan that gives them what they want. Everybody will have access to a choice in health in plans, just as every federal employee has choice in the FEHBP.

It is important to note that the wealthy in this country already are subsidizing health care for the very poor through the Medicaid program. This bill would make states more responsible for the Medicaid dollars they receive and give them a budget. States would have the incentives, via the tax credit to individuals, to give Medicaid beneficiaries a private insurance plan instead of a government program. This market-based approach leaves room for the generosity of the American people through various charity care venues as well.

Even though rough at times, markets help allocate resources. If we spend $2.2 trillion on health care and one out of every three dollars doesn't go to help somebody get well, we ought to change that system, wouldn't you think? We ought to change it in a way that will deliver health care. Why shouldn't we get that one out of three dollars promoting prevention or giving access to treatment?

What happens now is, we give access—delayed and emergent access—and then we cost-shift. This whole bill is designed to take all the cost-shifting out of the system. It is designed to take the Medicare cost-shifting out of it, the Medicaid cost-shifting out of it, and the charity care cost-shifting out so that everybody has access and everybody has equal care.

QUESTION: In rural areas, Medicare is a prime driver in access, and it's also the driver of cost increases in health care in America. How do the provisions in your bill affect Medicare, and how would it help contain cost growth and also ensure access to health care in Johnson County, Oklahoma?

SENATOR COBURN: The question is: Why doesn't Johnson County have access today? A doctor graduates from residency, fulfills the two-year obligation, goes to Johnson County, and, as soon as that two years is up, is gone. Why? Because the availability of earning power is limited by what Medicare says, because the vast majority of patients are going to be Medicare and Medicaid. What if we had a market that said we are going to pay somebody an appropriate amount to live in a rural area and care for those folks?

QUESTION: So what does your bill do to fix that?

SENATOR COBURN: It creates a market. We allow Medicare to continue, but we allow somebody like yourself—on a completely voluntary basis—to start putting your 2.9 percent FICA taxes into a medical retirement account so that 45 years from now, you can take whatever that credit will be worth, based on the CPI updates, and add it to your medical retirement account. You can then buy a lifetime health insurance policy instead of switching to a government program the day you turn 65.

Why shouldn't you be able to keep the same health insurance and doctor that you've always had? Why should you have to be in a Medicare system that pays a third of what it actually costs to do some things?

Medicare's payment rules are always two or three years behind the latest treatment, so seniors do not get it because somebody in the bureaucracy has not approved the latest treatment that saves lives and money. It is that bureaucracy of medicine, which has been copied by large insurance companies, that has restricted some access to care and some improved quality care in the name of saving money. I believe markets will do a far better job than CMS[5] ever could do in figuring out what to pay for things and what their relative worth is.

5. The Centers for Medicare and Medicaid Services, an agency within the U.S. Department of Health and Human Services that is responsible for administering Medicare, Medicaid, and the State Children's health Insurance Program (SCHIP).

DR. BUTLER: I'd ask Joe and Grace-Marie to join us to make some comments on the proposal and the legislation. Both Joe and Grace-Marie have worked on the same issues that the Senator has focused on for many, many years, and I'm sure we'll have very insightful comments about the approach that Senator Coburn has taken.

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. He also serves as a commissioner on the Maryland Health Services Cost Review Commission and is an adjunct professor at the School of Public Health at the University of North Carolina. He's worked with us at Heritage and all of us in the field for many, many years on Medicare reform, on insurance regulation and the uninsured. He's also had a long career in the government at the Congressional Budget Office, the Council of Economic Advisers, and the Office of Management and Budget and has been a consultant for the World Bank in such exotic places as Bulgaria, Croatia, and the Czech Republic.

Grace-Marie Turner is the founder, President, and Trustee of the Galen Institute. The Galen Institute and Grace-Marie also for many years have been working on the same broad issues of health care and the tax treatment particularly and tax policy generally. She was Executive Director of the National Commission on Economic Growth and Tax Reform in 1995 and 1996 and has been very instrumental in the promotion of consumer-based health care and health savings accounts and a whole range of issues that the Senator touched on.

Before I ask Joe to make a few quick comments, let me just note that a central part of the Senator's proposal touches on what one might call the elephant in the room: the tax treatment of health care, which is so much a factor in the system we have today and also a barrier to the kinds of changes we need to move toward in terms of a consumer health care system. So it's a very gratifying and, I think, critical part of the proposal to have a fundamental reform of the tax treatment of health care.

I think that's an idea whose time has come. The President has put forward a proposal to limit the tax exclusion for company-provided coverage and look at opening up other tax relief for people who don't have that coverage. There have been proposals on Capitol Hill, proposed by organizations like Heritage and others, to institute forms of refundable tax credit, or rebates as the Senator called them, to begin to change that tax treatment.

The tax relief for health care for individuals in this country is now over $200 billion a year. That's an enormous incentive and subsidy, but it's very skewed toward one form of coverage, as the Senator laid out, and really forces you to enter a Faustian bargain: to hand over the entire control of your health care insurance to your employer as a condition for getting that release.

Addressing that fundamental inequity and unfairness and disempowerment of the current tax system is absolutely critical to bringing about the kind of consumer system that the Senator laid out and to beginning to address the perverse incentives that we currently have, both to overuse services in some areas and not to have any help to get them in others. So it's very, very important, and I applaud the Senator for making this a central part of the legislation.

JOSEPH ANTOS, Ph.D.: Senator Coburn, you're not fooling around with little ideas. They're all big ideas, but they're politically difficult.

The Commonwealth Fund spends a lot of money studying health policy, and they have a new report analyzing the leading congressional health care bills. I didn't see yours in here, but if you read the table of contents, you see the kind of ideas that are the leading ideas today. Some of them are pretty good. The first one on their list does in fact deal with the tax treatment of health insurance—they couldn't avoid that; the President mentioned it. But then there are some other ideas that might be a little more questionable.

Federal–state partnerships to expand health insurance sounds good until you realize the bill they're talking about is one where Congress sets up a committee to decide what the good ideas are. Expand coverage through Medicaid; Medicare buy-in for older adults; universal coverage of children, which means through a federal program; expanding Medicaid and SCHIP coverage to families; employer

mandates for large employers; and improving the affordability of coverage for small businesses, although it isn't entirely clear what that means—the Commonwealth Fund's list didn't include many free-market ideas, and your proposal is a refreshing counterpoint to that.

Let me mention a couple of issues specific to the Coburn proposal. First, on the tax treatment, something Stuart didn't mention is that your bill would allow employers to contribute to employees' health insurance premiums regardless of where they bought the coverage. That makes it possible to come up with a more sensible tax treatment for health insurance without destroying the current insurance arrangement that nearly everybody has. This is the kind of innovative approach that should be addressed in open debate on the Hill.

On private insurance, you support the idea of allowing people to buy insurance no matter where the insurance company happens to be located; you include some regulatory provisions that are meant to protect consumers from fraud and that would be run by the state where you live. So you're protected in two ways: by the state where the insurance company is located and the state where you live.

Interestingly, one of the things that you left out, which I know Stuart is concerned about, is a Massachusetts-like connector. Your view, apparently, is that the private sector will figure out how to market insurance to individuals, and, in fact, there is ehealthinsurance.com that does just that. It is actually possible to buy insurance without creating a government organization. I'm in favor of making it as easy as possible for people to buy insurance, but I share your skepticism about that particular model. I think it's worth looking at, however.

I wanted to dwell mostly on Medicare. I think the Senator's proposal is very daring, almost dangerous. It opens up the Medicare program potentially to almost any insurance that's sold in America. In other words, it offers insurance choices that Medicare beneficiaries don't have right now.

In essence, to suggest a phrase, you're proposing something that I would call "health insurance for life." When you're 20 years old or 22 years old, you can buy insurance that suits you; as you go through your life and through your career, you can change what you buy; and then, when you enroll in Medicare, you don't necessarily have to change just because you turn 65. That's an important principle, the idea of allowing people to have continuity in the coverage that they have. There are a lot of difficulties in making that happen, but the principle is very sound.

Another point that I would emphasize is that Medicare beneficiaries under the Senator's bill would have the choice of staying in traditional Medicare or opting out completely. The material that I read from his office doesn't mention the "V" word—voucher—but essentially, the Senator has come up with a way to give people the value of Medicare while allowing them to buy on the private market the kind of coverage that they think they want.

There are real issues here. Since this would be voluntary, selection bias could be a problem. Leaving that aside, a system that allows Medicare to transform itself, not abruptly but over a period of time, is a sensible objective, but the details need to be worked out.

There are carrots associated with this. One of the carrots is that you get various kinds of tax breaks to buy private insurance, which will stay with you if you opt out of the traditional Medicare program and buy private insurance. That's a gigantic carrot.

There is also a stick. The Senator would take the President up on his proposal to eliminate the indexing of those income thresholds for Part B premiums. As you know, starting this year, higher-income beneficiaries have to pay a somewhat higher premium to participate in the Part B program. The Senator basically would allow that schedule of higher premiums to remain constant in nominal dollars so that over time more people would be required to pay higher premiums. If the traditional Medicare program looks worse and worse, seniors will be more likely to consider another option.

I think there isn't enough focus in the proposal on slowing the growth of health spending. If Senator Coburn's bill could be passed, changes that would gradually accrete to the system would be very positive. But the problem is that the crisis is *now*, and we've been in that crisis for decades. So

part of the package ought to focus on cost-reduction policies that could take effect now.

Another element of the problem that needs to be dealt with is health information technology.

SENATOR COBURN: The federal government has already spent $200 million trying to establish health IT, and we should have let the private sector markets do that.

DR. ANTOS: Absolutely, but the government ought to get out of the way of progress as well. One of your proposals is to take a look at the Stark restrictions that prevent private subsidies to encourage the adoption of health IT systems. All I'm saying is that there are some issues that can be dealt with, and health IT is the easiest one to describe.

We also ought to work on comparative effectiveness research. Information is a public good, and the government is in the best position of all to collect information. In fact, Medicare collects information on millions of medical treatments and then doesn't use it to better understand what works and what does not. That should be fixed.

One could argue that there isn't enough detail in the bill, but Congress would take care of that. The first rule of Congress is, "If in doubt, micromanage." So the real issue is not a lack of detail, but the need to worry about allowing too *much* detail in the law as you go along. On the other hand, not enough detail is a CBO scoring problem, and as everyone knows, CBO scoring is a short-term analysis, not a long-term analysis. I think you've got real challenges there—we all do—in terms of reforming the system.

I don't think you allow enough competition in the Medicare program. Not on the Medicare Advantage side—you allow plenty of competition there—but the traditional program is going to be with us for a long time. I think we need to foster competition there as well.

Let me finish with one last point: This proposal has too many big ideas. There was a great article in *The Wall Street Journal* recently that got it exactly right. Quoting Mike Franc of The Heritage Foundation: "Republicans are still too preoccupied with health care small-ball." In other words, which procedures should be covered by Medicare, how much should generics cost—the details of running the health system as opposed to getting the broader picture. As Mike says, "This is still outside their intellectual comfort zone, and Republicans never do well in that situation. But to win this debate—the defining issue of the next 40 or 50 years—they are going to have to address it forcefully, head-on, and with every bit of their intellectual firepower."

Senator, I think you've started the ball rolling.

DR. BUTLER: As Joe said at the very beginning, you've got organizations like the Commonwealth Fund that try to determine what the debate is going to be on health care by drawing attention to some proposals and ignoring others. I think one of the things we've learned from Senator Coburn is that Senator Coburn is to the discussion of issues as Fox News is to the earlier networks, forcing his way into the discussion. I have no doubt that the Commonwealth Fund and others will be including these proposals in the future as the debate continues.

GRACE-MARIE TURNER: Senator, I am grateful to you for developing such a comprehensive vision of health care reform based upon your free-market perspective. I think it is very important for conservatives to understand that reform is possible that is built around consistent principles of individual responsibility, belief in markets, belief in competition, belief in freedom, belief in individual choice, and belief that we can move to a better health care system through the market forces that we know work in the rest of the economy. So I congratulate you on coming up with this comprehensive vision of free-market health reform.

I would like to focus on the Medicaid provisions of your bill, not only because I served on the Medicaid Commission, appointed by Secretary Leavitt,[6] but because Medicaid is now the biggest health care program in the country. It spends more money and covers more people than any other health care system, so addressing it is terribly important. Senator Coburn calls it "keeping Medicaid on mission," and keeping Medicaid on mission means taking care of

6. Michael Leavitt, U.S. Secretary of Health and Human Services.

poor people first and taking care of those who are most vulnerable.

The Senator would establish a budget for Medicaid, and he would tell the states that Medicaid no longer would be an individual entitlement to benefits. The states would be responsible for figuring out how to spend this money wisely and well. We heard many examples during our Medicaid Commission's work that the states could do this if they are given more flexibility and the proper incentives.

Under his plan, the states would have budgets for Medicaid, but they would have much more flexibility in how they would spend that money. For example, Senator Coburn describes elsewhere in his legislation a system of individual and family tax credits for health insurance. The bill would allow states to turn the Medicaid allocation into a defined contribution to supplement those tax credits. This would allow those with the lower incomes who are eligible for Medicaid to have the opportunity to purchase private health insurance.

That is a consistent theme running through the Senator's bill: that everybody should have the option of purchasing private health insurance. We shouldn't relegate people to a Medicaid ghetto because of their income category. Let them have the opportunity to purchase private health insurance, which means, in part, allowing them to use a Medicaid stipend to help buy into employer-based coverage if they have the option or to purchase coverage on their own.

Senator Coburn also is building on several successful models in his Medicaid reform proposal. For example, Cash and Counseling is a very successful program within Medicaid that allows people who are eligible for personal care services to essentially decide who they want to take care of them and their personal needs. Cash and Counseling allows people to have much more choice and control over the services that they receive, and the program's 98 percent satisfaction rate is testament to its success. These beneficiaries not only have a say over who provides their personal care, such as bathing by a daughter or niece rather than a stranger from a home health agency, but they also have counselors available who help them make decisions about how they are going to allocate those resources.

That's basically, as I understand it, the model of the Medicaid allocation in the Senator's legislation: Give people assistance; give them access to counselors to help them make those decisions; and give them information about the markets and the choices that are available to them.

A critical need for reform in the Medicaid program is to do a better job of helping those who are dually eligible for Medicare and Medicaid, whose care costs taxpayers $22,000 a year on average. These are often the most vulnerable citizens. They're both poor and, often, elderly. They are eligible for Medicare either because they are elderly or disabled or both, and for Medicaid because they're poor, but their care is incredibly fragmented through the current system.

What we need is to build incentives and a structure for a new kind of system to take care of these most vulnerable people. The Senator has developed an idea called Medicaid Advantage, which Bob Helms[7] and I initially developed for the Medicaid Commission. It was adopted by the Medicaid Commission as a recommendation, and I'm happy to see it incorporated in this legislation because in all of our hearings across the country for a year and a half, we kept coming back to the need to solve this central problem.

For example, we heard about a patient who was dual-eligible. She was in a nursing home that was being paid for by Medicaid. She had to be transferred to a hospital where her care would be paid for by Medicare. It took a week for her medical records to catch up with her in the hospital because she was operating between these two systems, falling through the cracks, diminishing the quality of care for this patient and costing the taxpayer more in duplicative and potentially even inappropriate care. No one is in charge of coordinating care for the people who most need it.

The Senator's idea for a Medicaid Advantage program once again builds on something we know works—Medicare Advantage, one of the most pop-

7. Robert B. Helms, Director of Health Policy Studies at the American Enterprise Institute.

ular parts of the Medicare program. Medicare Advantage gives seniors the option to participate in the same kind of private coverage that people have through the workplace: private health plans that can coordinate their care, including those with special needs, and that provide a single setting so that their records are integrated in one place. They can get their drug benefits, their preventive care, their hospitalization, their doctors' visits, and their lab tests, all coordinated through this one health plan. That's what our vulnerable dually eligible citizens need as well.

But in order to do that, we need to rationalize the funding. We don't want Medicaid to be paying for the nursing home and Medicare to be paying for the doctors' visits and hospital care in a fragmented system. What this proposal would do is put all those funds into one pool that follows the person so that the Medicare funds, the Medicare Part D prescription drug benefit funds, and the federal and state share of the Medicaid dollars follow the person. States can be in charge of figuring out how they can best allocate those resources to provide the best care for seniors and for others who are eligible for both programs.

We saw examples of how this works in states that are experimenting with a coordinated care model. Vermont, for example, has a hugely successful program that is able to get down to almost the individual level of patient needs for dually eligible citizens. We heard over and over that people want to stay in their homes; they don't want to go to nursing homes. Sometimes they need very specialized support to do that, but sometimes it can be relatively simple and inexpensive care but it isn't allowed because of the constellation of rules that govern both programs.

Senator Coburn's program would let states decide what services people need in order to be able to stay in their homes. Sometimes relatively simple technologies can provide the assistance that somebody needs to stay out of a nursing home. This plan could save money, make care more efficient, allow the competitive market to work within the states, and give the states a lot more authority and responsibility to make it work.

So I commend you, Senator Coburn, for your "consumer-directed market" approach and for envisioning a health care system that provides for individual freedom, competition, and choice and that looks to building a 21st century health care system.

SENATOR COBURN: As you look at what is going to happen to our country with Medicare and Medicaid, any responsible adult in this country would ask, "Do we have a responsibility to those who follow us, to the next generation?" We are on an absolutely unsustainable course to be able to keep the commitments that we have made in terms of Medicare and Medicaid. There is no question about that. Whether it is the Government Accountability Office or the Office of Management and Budget or the Congressional Budget Office, they all agree that we have promised things we cannot deliver under the present system. And when one out of three dollars we have promised is not doing what it is supposed to be doing, we need to change things.

I think it is really a moral question for us. As Joe suggested, we could say we are going to change this so we get more control of it. The fact is, it is really a question of selfishness. If you are a Medicare patient today and you say, "Medicare is a promise to me"—and what we know about the vast majority is that most people will get more out of it than they put into it—what you are really saying is, "I want my grandkids to pay for my health care." Is there any responsibility on us to try to change the system so that the burden that is going to be placed on the next two generations is less and at the same time create improved quality and access? I believe we can.

The other thing, I think, is that you cannot fix health care by looking with a microscope at the small areas; you have to address every aspect of health care at the same time. You have to address prevention. You have to address liability because it's such a large component. You have to address service delivery. You have to address access.

When we talk about the cost of keeping somebody in their home versus in a nursing home, it's about 60 percent of what it costs to keep them in a nursing home, even having to pay workers to come in to take care of your family. What we know from that is that they live longer and have better quality.

Why would we not want to do that? Well, we have a Medicaid system that does not encourage that. Why wouldn't we want states to be able to do that? Why wouldn't we want the ideas of everybody in this country that's helping to pay for this system to be able to contribute on a state level to improve quality and improve access?

There is going to be a selection bias in everything we do. Oklahoma already has a high-risk pool. We've further incentivized high-risk pools in this bill. In terms of the insurance industry, if this is truly implemented, there will be little advantage to cherry picking in underwriting insurance based health status, because the insurance company will pay for it one way or another. Insurance companies will get dinged at the end of the year based on an industry-regulated pool, much like the country of Switzerland has in place, to help pay for those people that they have denied care. To address that problem, we want to create more of a true insurance market.

We know we have a long way to go in the health care debate. What we tried to do with this bill was not think of politics. We tried to think of what needs to happen for us to have a vibrant, progressive, improving, and more efficient health care system that will give quality and access to everybody in this country.

When you start thinking about the politics, you start to think about what you cannot do. We realize there are going to be a lot of criticisms of this bill, but we do know principles that work in this country, and we know things that we have been very successful with. If we refuse to do that in health care, we will pay the price for that. We will pay the price in terms of global competition. We will pay the price in terms of innovation. We will pay the price in terms of lack of quality of care and prolonged lifespan. There is a cost of what we do not do.

We have tried not to think about the politics of this, thinking that if the American people really like liberty, really like choice, really like freedom, and really like this idea of fairness—then why shouldn't we have a tax code that is fair to everybody and allows people to have the same shot? Why shouldn't Americans get to decide where they buy their health insurance? And along with that comes some personal responsibility.

There is no such thing as total dependency by active adults in this country, and no longer can our country afford for individuals to say, "You owe it to me." Nothing is owed to anybody, because what we are owed today is coming off the backs of our grandchildren. So the way I address seniors when they talk to me about how they do not want anything changing is to say, "Then you don't want your grandchild to have a college education, because that's what you're going to steal." There is a $70 trillion unfunded liability in Medicare alone that we're adding to the next couple of generations. We have to be about addressing that today. Instead of saying "You owe it to me," we should be asking, "What do we owe to our grandchildren?"

We cannot wait to do that. We cannot worry about the politics of it. Let's think about the principles. Let's think about the policies. Let's think about intergenerational fairness. Let's think about the heritage of this country. It is: one generation will sacrifice for the next to create greater opportunities and more freedom. That's what we need to be thinking about, not the politics.

So I am happy to have all the political criticism that is going to come with this bill, and I am anxious to debate anybody on the idea of freedom and choice and true competition in any market. I believe it works. I believe that in my group, my peers, the physicians in this country are fed up, and if you asked them tomorrow, they would probably all take a government-run system.

But that is not the best thing for our country. That is not the best thing by far. It is certainly not going to be the best thing for quality, and it ultimately will not be the best thing for access and improvement. So what we need to do is be bold about what we are talking about and be able to defend it. We know this bill is not perfect; we are willing to take other market-based ideas to make it better; but you cannot fix health care by just assuming we can take it all under the government's wing and it is all going to be solved. It is not. It is going to be worse; it is not going to be better. As P. J. O'Rourke said, "If you think health care is expensive now, wait until it's free."

QUESTION: Senator, just a detail question. Do you anticipate that your legislation will be acted on

as a whole, or do you think you will be ending up with a strategy that will have it broken down into amendments on different bills? What committees has it been referred to, and do you anticipate any action in those committees?

SENATOR COBURN: I think this bill ought to be the standard to which any piece of health care legislation ought to be compared. You can create medical retirement accounts for people of Medicare age, but if you don't fix the rest of the problems with the health care market, they will not be able to afford it. We have to address the problems that are limiting access, raising costs, and decreasing quality.

I am sure it will go to the Health, Education, Labor, and Pensions (HELP) Committee and the Finance Committee. We are working to get cosponsors in the House, and very soon, I think we will have eight Senate sponsors, which is not a bad number of sponsors for a bill this big.

QUESTION: My wife and I recently had to go to the private-sector individual market to purchase coverage because we're both independent consultants. Each of the topics you mentioned—slightly elevated blood pressure, cholesterol, getting a colon scan, getting a lump checked out—turned out to be fine, but each of these factors was used by private-sector companies either to deny us coverage completely or to grotesquely raise the price at which they'd be offering it. How do you suggest addressing that problem?

SENATOR COBURN: One is what I talked about in terms of high-risk pools, which will discourage insurance companies from saying, "Well, they're going to be highly expensive, so maybe we don't want to cover them."

If we have a high-risk or reinsurance pool that they all have to contribute to, based on revenue versus loss, there is little reason for them to deny you anymore because they are going to pay for you anyway. So we make insurance again truly insurance. Right now, when you buy insurance, you are asking them to take 20 percent off the top and then pay your medical bills. We are not spreading risk. What the insurance companies typically try to do is get rid of any high-risk stuff so they can exaggerate their profits.

What we need is competition. Big insurance is probably going to fight this bill because they are making a killing. When a big insurance company in *The Wall Street Journal* is telling them that they are fining doctors because they cannot send them to a lab they think is better than some lousy quality somewhere else, you take the professionalism out. When you have real competition, that will not happen. One of the things the American Medical Association has always tried to get is to allow doctors to come together to set their prices. If you have to publish your prices in a transparent market, you will know what everybody is charging.

If we are going to have a truly transparent market, doctors can charge what they want. Maybe they will not get used, but maybe they will. Maybe Dr. Joe, who has the best bedside manner, has the best art of medicine, has the best training, the best diagnosis, and the best result, ought to get paid more than Dr. Tom, who has the poorest bedside manner, is very curt, doesn't spend any time with you, and doesn't do a good job of diagnosing. Maybe the bad doctors will get retrained or forced out.

Remember: The other thing that is coming is that we are going to have a shortage of some 200,000 doctors over the next 50 years in this country. Nobody is even talking about that. The good doctors are retiring. They are retiring from medicine. They are leaving because they are frustrated with it, and there has been this massive change that has occurred. Let's fix it all. Let's address every issue that is impacting health care today, whether it is liability, markets, access, or competition.

The other question, I again would ask is this: When we say we are going to cover a veteran or we are going to cover a Medicaid patient or we are going to cover a Native American and then we give them inferior quality, have we met the expectation that we promised them? No, we have not. And that is what we have done.

Many times, what we have promised is inferior. The best example on that is that now dental assistants can do root canals in Alaska. You really want a dental assistant doing your root canal? But that is what we are giving Native Americans. That is what we have told them: "We're going to allow some extender, some physician extender, to give you care."

Maybe that will be good care, but sometimes it is not, and if we do not need four years of medical school and four years of residency on average in this country now, why don't we get rid of them? Why don't we just make everybody a PA or a nurse practitioner? That is the option. So the assumption behind this lower level of care, even though we are saying we are meeting our commitment, is a moral question as well.

GRACE-MARIE TURNER: When you are shopping for health insurance, the insurance company may very well look at you as though you have a fire smoldering in the basement: Why are you in the individual market buying health insurance now? They think you may know more than they do about your health problems, and the companies may be pricing insurance to protect themselves against the fact that you may be buying health insurance before a major health event. But if you had the kind of insurance that Senator Coburn is talking about, where you have continuity of insurance over your lifetime, then you can buy a longer-term care policy, and you would have less risk of facing prices with a defensive premium.

It is important that people be able to purchase health insurance that has continuity of coverage so that you are investing in that policy that you may own for years. You would have a relationship with the company, but you also would have the ability to move companies as long as you maintain continuous insurance coverage.

But our current system doesn't provide for continuity of health insurance; health insurance is repriced year after year. Worse, people with insurance at work get thrown out of the market altogether if they leave their job, start a new business, or get fired. Continuity, portability of health insurance, and long-term contracts would solve many of the problems in our health sector today.

SENATOR COBURN: I completely agree. One of the misunderstandings about the non-group insurance market is that people often say it is a dysfunctional market that does not work. Actually, the problem is that it works all too well in the sense that people in that market are required to pay what the insurance is worth to them. They are not subsidized, and the microscope is on them the first time they apply.

The other thing that many people may not understand is that once you get coverage in the individual, non-group market, if you maintain that coverage, insurance companies do not up your rates just because something happened to you a couple years down the road. They tend to raise rates only on the basis of age. This is the general practice throughout the country.

So the real problem a lot of people have, beyond what Grace-Marie is saying—that they did not buy insurance when they were young and were able to maintain it—is this unfair tax subsidy system we have and this complicated and confusing system where employers are "giving" us a benefit when, in reality, those of us who have employer-sponsored coverage are giving it to ourselves by taking lower wages. It's a confusing system, but sticker shock still matters. Individual Americans, not employers, should be able to take direct advantage of tax breaks for health insurance—wherever they choose to.