A not-for-profit health and tax policy research organization

Competition in the Health Care Marketplace

Testimony before the U.S. Senate
Committee on Commerce, Science, and Transportation

Consumer Protection, Product Safety, and Insurance Subcommittee

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By Grace-Marie Turner, Galen Institute

Thank you Chairman Pryor, Ranking Member Wicker, and members of the committee for the opportunity to testify today on the issue of competition in the health care marketplace. My name is Grace-Marie Turner, and I am president and founder of the Galen Institute, a non-profit research organization devoted to advancing an informed debate over market-based health reform ideas.

There are many problems in our health sector that require careful and deliberative change, including the issue you are exploring today involving the lack of competition in many parts of the health sector. I would argue that many of the problems the country is facing involving cost, quality, and access to health care could be addressed by encouraging more competition and empowering consumers to have greater control over decisions involving their care and coverage.

In my testimony, I will highlight some of the progress that is being made through innovations in care delivery, in creative benefit offerings, and even in lowering the cost of treatments to show that the competitive market can respond to the demands of consumers for better quality care at more affordable prices.

While health care is different than other sectors of our economy and requires special consideration, there are many areas where consumers can and want to have more control over their health care choices. I believe the evidence shows that competition can work by engaging consumers as partners in getting better value for their health care dollars.

Change is indeed needed

Congress is attempting to address in major health reform legislation the many problems in our health sector: Health insurance and health care still cost too much. As a result, tens of millions of Americans don't have health insurance, and many more are worried they are one pink slip away from losing their coverage. The lack of competition in health insurance in many states limits the options for coverage and over-regulation drives up costs. And the costs of Medicare and Medicaid are swallowing up a growing share of federal and state revenues, compromising other functions of government and threatening huge tax increases just to pay for current entitlement commitments.

But because Americans consistently tell public opinion pollsters they do not want a larger role for government in the health sector, policies that build on the private sector are much more likely to gain public acceptance.

Consider, for example, the progress that has been made in moderating costs over the last several years:

- In 2007, U.S. health spending grew at its slowest rate since 1998, increasing just 6.1 percent, with year-over-year increases of 6.7 percent and 6.8 percent in 2006 and 2005.[1] These increases are still higher than the general inflation rate, but not the double-digit spikes seen over the last several decades.

- Premiums for private health insurance also rose by only 6 percent in 2007, the same rate as in 2006, but much lower than the peak of nearly 11 percent in 2002.[2]

- Premiums for new consumer-directed health insurance plans introduced in this decade increased by much smaller amounts – 2.8 percent in 2005 and 2.6 percent in 2006 – helping to moderate costs overall.[3]

A climate friendly to innovation

The private sector is much more adept at innovation and evolutionary change than government-dominated programs. Continued innovation is vital to progress in health care. The medical profession is moving toward patient-centered medicine, with micro-targeting of treatments tailored to the individual genetic code of individual patients. Advances in medical science demand that progress continue without being blocked by regulatory obstacles and restrictive payment systems.

Two segments of the health sector

The U.S. health economy has two distinct segments – the public and private sectors – and each operates under different sets of rules. About 46 percent of the U.S. health sector is largely financed with tax revenues through government-operated programs, such as Medicare, Medicaid, the State Children's Health Insurance Program, the Veterans Health Administration, community health centers, and others. The rest of health care is financed privately, largely through businesses' contributions to support employment-based health insurance but also through direct purchase of insurance and out-of-pocket payments by patients.

Many analysts refer to our public and private health sectors as a health care *system*, but we do not have anything approaching a health system in the U.S. Rather, it is made up of conjoined twins, with one run by various government agencies and the other more reliant

upon market forces. As health policy analysts attempt to achieve consensus on reforms for our health sector, it is becoming increasingly clear that this operational divide is one reason compromise is so difficult.

The government sector works primarily on a model that provides people eligible for public programs with an entitlement to a government-determined set of benefits within government-determined payment structures. Some patients receive care from physicians employed by the government in government-owned facilities, but most obtain care through private hospitals and physicians who are paid at government-determined rates.

Within the public sector, private health plans also are involved. For example, many states have contracted with private managed care companies to offer care through their Medicaid and SCHIP programs, and Medicare allows participation by private plans in Medicare Advantage and the Part D prescription drug benefit program. But the majority of publicly-financed health care is delivered through the fee-for-service (FFS) model that the private sector largely left behind in the 1980s as unacceptably expensive and inefficient. The response of the public sector to these problems has been to place restrictions on benefits and payments to providers in an effort to restrain costs, which often result in patients having difficulty accessing services and providers.

The private health sector is much more diverse in its range of options and payment systems, representing an alphabet soup of program options from PPOs, POSs, MCOs, and HMOs to HSAs, HRAs, FSAs and even FFS.[4] Private health plans, employers, and countless other companies in the health sector are continually innovating to provide more options for care and coverage. But the centralized control of health care even in these private sector plans limits and restricts consumer choices, giving them fewer options than they would have in a more competitive and open marketplace, as we have written in numerous papers, articles, and our book, *Empowering Health Care Consumers through Tax Reform*. (For more information see www.galen.org.)

For example, most people with employment-based coverage have limited choices of plans offered by their employers. And many of these plans contract with a limited number of pharmacy benefit managers (PBM) who determine which drugs will be covered and what copayments will be. Patients can be given incentives to purchase one drug over another, not because it may be the one their doctor thinks is best for them, but because the PBM has a special deal with a particular drug company to push their product. This lack of transparency limits consumers' choices and rightly often angers them.

We do need changes that would make the private market for health care in the United States more open and transparent. Yet, it is instructive to look at the innovative ideas coming from the private sector for improvements in the delivery and financing of health care where competition, transparency, and consumer choice are working.

Private sector innovation

Entrepreneurs and private investors have been making significant investments in new health care solutions: MinuteClinics, TelaDoc, specialty hospitals, innovative medical practices, and employer plans that empower consumers to engage in their health care and spending decisions are just a few examples.

Here is a summary of some of the other countless private sector initiatives in care, financing, and delivery:

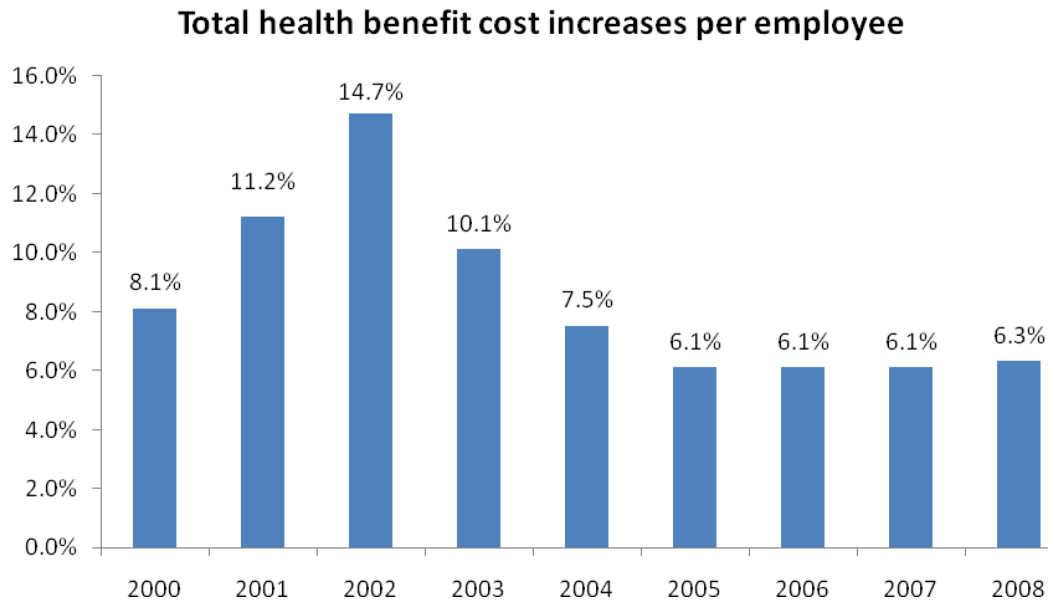
Employer innovations

Many leading employers are working to get better value for spending on health care and health insurance for their employees in order to shape their health insurance offerings to fit their resources and workforces. A few examples:

- Safeway chief executive Steve Burd has become an evangelist for wellness incentives in the company's health insurance arrangements. In the first year after these plans were introduced, the company's health costs went down 11 percent. "If you design a health care plan that rewards good behavior, you will drive costs down," he said.[5] The company shared its cost savings with employees, cutting their costs by 25 percent or more. Safeway introduced a program called Healthy Measures that encourages employees to get health assessments and provides support and incentives for responsible health behaviors. Safeway also covers the full cost of recommended preventive care.[6]
- Target offers its employees a range of health insurance choices. One Health Savings Account option costs them as little as $20 a month, and Target contributes $400 a year to health spending accounts for individuals and $800 for families.[7] "We've seen, and national research supports, that team members make more cost-conscious decisions when they participate in a consumer-based plan," according to John Mulligan, Target's vice president for pay and benefits. "These plans engage our team members in a decision-making process that gives them greater ownership and control of their health care dollars." The company offers its 360,000 employees Decision Guides to help them compare price and quality and estimate their costs, plus access to wellness programs, a nurse hotline, and other support tools.[8]
- Wal-Mart offers dozens of health plan options to its employees, one with premiums as low as $5 a month. For this, employees receive a $100 health care credit, more than 2,400 generic drugs available for $4 a month, and major medical coverage with no lifetime maximum that starts at $2,000 – basically the moment they step into a hospital. Employees can choose to pay higher premiums for lower deductibles and more comprehensive coverage.[9] For $62 a month, employees can choose a $500 deductible policy with a $100 health care credit and no lifetime maximum on their insurance coverage.

- Whole Foods' CEO John Mackey toured the country talking to employees about health benefits options. Afterward, employees voted to switch to new account-based health plans with higher-deductible insurance coverage. Whole Foods deposits up to $1,800 a year into a spending account for each employee, with Mackey pointing out that this is not charity but part of the employee's compensation package. If they don't spend the money on medical care, it rolls over and the company adds more the next year. Some workers have as much as $8,000 in their accounts.[10] Whole Foods saves money and still covers 100 percent of its employees' health insurance premiums.

These companies and many others have worked extraordinarily hard to find the delicate balance between getting health benefit costs under control and continuing to provide coverage that satisfies their workers. There simply is no way that a benefit or cost structure dictated by Washington could achieve these same results. Maintaining ERISA protection is crucial to allowing companies to continue to innovate.



Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1988-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1988-2008.

New health care financing options

Several new private sector health coverage options are available to companies and individuals. For example, the Medicare Modernization Act authorized the creation of Health Savings Accounts (HSAs)[11] in 2004, with further enhancements enacted in 2006 and before that with creation of Health Reimbursement Arrangements (HRAs).

HSAs permit individuals to combine health insurance with a tax-free health spending and savings account. The account is used to pay for routine health care expenses, such as

doctor's visits, for services not covered by insurance, and to create a cushion to pay premiums in lean economic times. The high-deductible insurance policy covers larger medical expenses such as hospitalization and surgeries. Federal law also allows the insurance contract to cover preventive care, such as cancer screenings.

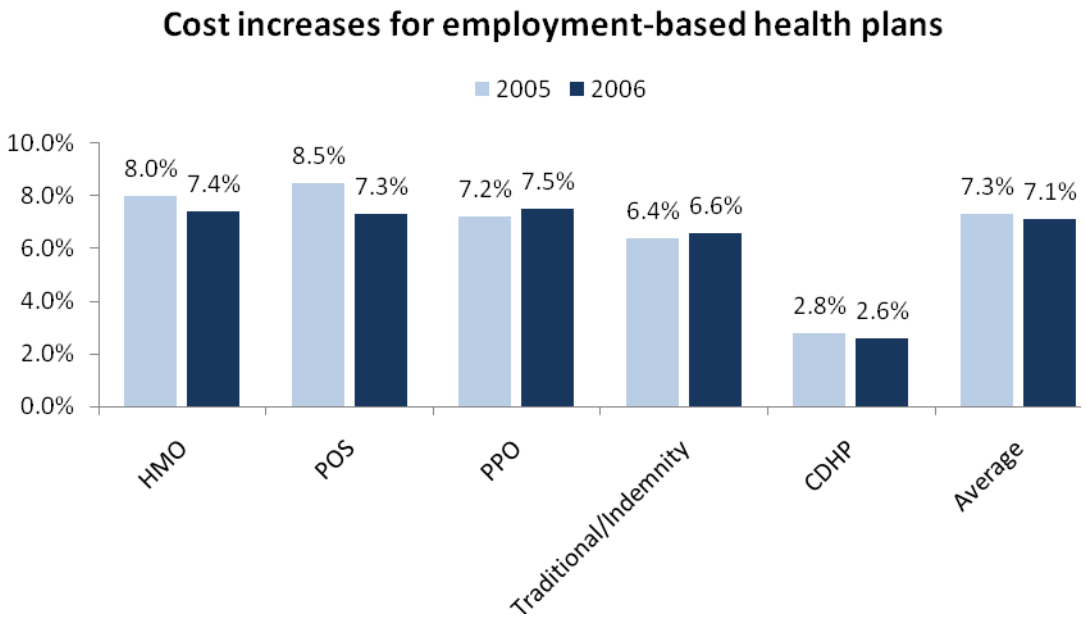
Eight million Americans had health insurance that qualifies holders to open HSAs as of January 2009.[12]

The older sisters of HSAs, Health Reimbursement Arrangements, were created via a regulatory interpretation in 2002 to give employers more flexibility in structuring health coverage for their workers. HRAs operate much like HSAs but can be offered only through the workplace. They are generally account-based plans accompanied by health insurance. While the money in HSAs is truly portable to the employee or individual holder, access to HRA funds is generally restricted after an employee leaves a company. But HRAs give employers more flexibility in shaping their benefit packages, including providing incentives for prevention and wellness activities.

Both products are helping to make health insurance more affordable and are helping companies lower their health costs. Health insurance premiums generally are lower than average because deductibles are higher, and the savings on premiums can help fund the HSA or HRA.

Companies that have introduced health plans with new incentives for consumers to be engaged as partners in managing health costs generally have seen lower-than-average health cost increases. Annual premium increases for employment-based coverage averaged about six percent for the last three years, down from double digits earlier in the decade.[13] The most impressive results have come from consumer-directed plans such as HSAs and HRAs.

Deloitte's Center for Health Solutions found that cost of consumer-directed health plans (CDHPs) increased by only 2.6 percent in 2006 among the 152 major companies it surveyed. This is about a third the rate of increase for traditional plans.[14]



Source: "Reducing Corporate Health Care Costs: 2006 Survey," Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions, 2006.

Lower costs of insurance coverage

Consumer-directed health products have helped to moderate health cost increases overall.

- UnitedHealthcare found that employer health benefit costs were more than 15 percent lower in 2007 for its HRAs than for traditional PPO plans. Importantly, 85 percent of the cost savings were attributable to lower utilization costs, such as avoiding hospitalizations and greater use of generic drugs – and not from cost shifting to employees.[15]

- A Mercer study found that consumer-directed health plans delivered substantially lower cost per employee than either PPOs or HMOs in 2008. CDHP medical plans averaged $6,207 per employee, compared to $7,768 for HMOs and $7,815 for PPOs.[16]

- In addition, health insurance that people purchase in the individual market is often more affordable than employment-based coverage. eHealthInsurance, the largest online broker for individually-purchased and small-group health insurance, found that the average yearly health insurance premium in 2007 was $1,896 for individuals and $4,392 for a family.[17]

Other benefits

In addition to moderating cost increases, HSAs also are providing new options for the uninsured. Up to 43 percent of those enrolling in HSA-qualifying health insurance were previously uninsured, showing that uninsured Americans in particular have been looking for an affordable alternative to traditional health insurance, according to Assurant Health.[18] Assurant Health's most recent data show that they have broad appeal:

- 66% of HSA purchasers are families with children
- 63% of HSA purchasers are over age 40
- 52% of all HSA purchasers have high school or technical school training as their highest level of education
- 30% of HSA purchasers have family incomes of less than $50,000

UnitedHealthcare found, based upon a survey of 300,000 HSA owners, that the average account holder had household income of $55,500, and 25 percent of those with an HSA had income of less than $39,000.[19] Changes in federal law in 2006 allowing employers to make larger deposits for lower-income workers also are apparently succeeding, since UnitedHealthcare found that they were more likely to have employer contributions in their HSAs than higher-income HSA holders.

Other private insurance options

Many other employers are offering innovative programs to help their employees get and stay healthier and spend health care dollars wisely. They are offering incentive programs to encourage employees to get health assessments to detect problems early and health coaching to help those with chronic illnesses better manage their care. These companies generally work in partnership with health plans to design the consumer-based products, manage the finances, educate employees about using them, and provide wellness programs and support for employees with chronic conditions.

For example, in 2005, Aetna launched a program that offers a range of consumer-support tools to help patients find physicians, compare costs and quality, and get personalized information about medical conditions and treatment. Its personalized search engine provides health information tailored to patients' individual needs.[20]

The results show this patient engagement works. Aetna is following health care claims and utilization of 1.6 million members of its Aetna HealthFund consumer-directed plans. Four years of evidence show sustained savings, more patient engagement in managing health, and greater utilization of preventive services. Employers who offered an Aetna HealthFund plan lowered their health care spending trend and saved money through all four years with the plan, across all Aetna products they offered.[21]

Aetna studied its members to identify the keys to successful implementation and found the keys were *greater* spending on preventive care, including wellness programs;

focusing on employee communication and education; and carefully structuring benefits packages with appropriate levels of employee responsibility.[22]

Many companies are offering turnkey solutions to health plans and employers. U.S. Preventive Medicine, for example, offers employers packages of services they can tailor to fit the needs of their workforces for preventive care services.[23]

In addition, a galaxy of websites has evolved to offer everything from treatment information to diet advice. EverydayHealth has just surpassed WebMD as the most-visited site for medical information, and new sites appear every day to help patients find the best doctors, the lowest cost medicines, and the most cost-effective diagnostics.

Lower drug costs

Competition, primarily from greater use of generic drugs, helped to moderate prescription drug spending. Prescription drug spending increased only 1.6 percent in 2007, the slowest rate since 1974. [24] Part of the reason is increased use of lower-cost generic drugs, but private competition over drug pricing in the Medicare Part D program also contributed. And retail establishments also have engaged in private price wars. In 2006, Wal-Mart began offering 30-day supplies of several hundred generic drugs for just $4. Competitors quickly followed suit, with some even offering to fill prescriptions for antibiotics for free. It's impossible to imagine this happening in a price-controlled, government-regulated environment.

There also has been active engagement by pharmaceutical companies in creating programs for low-income and uninsured people to obtain their products at little or no cost. Pharmaceutical companies have made significant investments to develop, expand, and promote patient assistance programs like Together Rx Access, Pfizer Helpful Answers, Partnership for Prescription Assistance, and many others. New private partnerships, like the Asheville Project and the Ten Cities Challenge, also have been created to help patients with chronic illnesses, including diabetes, get the medicines and counseling they need to manage their diseases.[25]

The private sector also has demonstrated its responsiveness to crisis. After Hurricane Katrina, more than a million people were displaced. They not only lost their homes, but also their support communities, including their physicians whose offices were literally washed away in the storm. Many were on important medications but the records of their prescriptions were lost.

Pharmacy chains, pharmaceutical companies, pharmacy benefit managers, physicians, technical experts, and philanthropic groups came together to create KatrinaHealth.org, a website that compiled pharmacy records and allowed physicians anywhere to access through a secure website the medical records of displaced patients who came to them for help. It was a remarkable achievement that showed the power of private enterprise to respond quickly in a crisis.

Innovation in medical treatment

The lists of innovations in medical treatment could consume a library. From pharmaceuticals to biologics and new medical devices, diagnostics, and surgeries, the list is endless.

For example, proton beam therapy can vaporize tumors with no damage to nearby tissue, and DNA mapping already is allowing doctors to determine before chemotherapy is begun which cancer patients will respond to which treatments. Telemedicine is extending the reach of medical skills to rural areas, into people's homes, and even to other countries.

Modern pharmaceuticals are dramatically expanding life expectancy and quality of life. Pharmaceutical research continues to be one of the most costly – and risky – investments in the health sector. In 2007, the pharmaceutical industry spent nearly $59 billion on research and development. Yet only 24 new drugs were approved last year.[26] For every 5,000 to 10,000 compounds tested, just five will make it to clinical trials. And only one of those will receive FDA approval. And then, only two out of every 10 drugs that reach the market will recoup the costs invested in creating and developing the drug.

Yet innovation in this sector is particularly important to overall cost savings as every additional dollar spent on newer drugs in the United States saves $7 in other costs.[27]

The U.S. continues to lead the world in medical research. In 2007, more than 2,700 compounds were in development in the United States, compared to 1,700 in the rest of the world, 1,400 of which were under development in Europe.[28] The U.S. is indeed the medicine chest for the world.

The most important role for government is to support this innovation in life-saving and life-enhancing medicines. Policies that would tax away the money that pharmaceutical companies spend on research would lower the quality of care for this generation and future generations.

Care delivery

Private health care firms have responded to consumer demand for more convenient, accessible medical care. For example:

- TelaDoc offers its customers telephone consultations with physicians from wherever they are, anytime of day, 365 days a year. The average patient gets a call returned by a doctor in less than 40 minutes, and the cost per call is just $35. TelaDoc physicians also use electronic prescribing to minimize errors and keep a record of patients' medications.[29]

- There also has been an increase in the number of low-cost walk-in medical clinics like RediClinic, Take Care, and MinuteClinic. There are now more than 1,175 retail clinics nationwide, a net increase of 274 new clinics opening in 2008.[30] They are usually located in malls or chain stores and are typically staffed by nurse practitioners working in conjunction with local doctors and hospitals to diagnose and treat common illnesses. They are open seven days a week, before and after work, and prices are a fraction of emergency room charges.

  These clinics use Mayo Clinic and Cleveland Clinic protocols to diagnose and treat a range of routine health problems, from allergies and bronchitis to poison ivy, ear and bladder infections, and strep throat, usually for a fraction of the cost of hospital emergency rooms. Wal-Mart found that about half of the people visiting its in-store clinics were uninsured and did not have other sources of care. Wal-Mart partners with local hospitals and doctors' groups to create the clinics in many areas, but it insists that all of them create electronic health records for every patient that are accessible at any other clinic in the chain.

- Specialty hospitals owned by physicians are showing the value of focused care in delivering high-quality, efficient care with greater patient satisfaction and better health outcomes.

- Physician practices also are innovating to become more consumer-friendly. Some are opening an hour or more a day for same-day appointments. Others are working with employers to staff on-site clinics so employees can see a doctor without taking time off work.

- Hospitals are experimenting with new ways to ease crowding in their emergency rooms, visited by an estimated 119 million patients in 2006. There are more than 8,000 walk-in urgent care facilities nationwide staffed by practicing physicians. Inova Health System and Shady Grove Adventist in the Washington, D.C., area and dozens of other hospitals nationwide are opening free-standing emergency facilities to treat everything from lacerations to heart attacks and gunshot wounds. Patients are seen faster, and if they need to be admitted, they are transported by ambulance to nearby hospitals.[31]

- A growing number of physicians are experimenting with innovative medical practice design,[32] including direct medical practices. Physicians, generally internists or family practitioners, contract directly with their patients to offer a medical home, providing medical care, consultation, and coordination with specialists for a fixed fee. The fees range from $60 to $15,000 in some practices, but generally cost about $1,500 a year.[33] Other physicians are bypassing insurance and simply posting prices for medical services. They find they can charge patients much less because they save on the administrative overhead of insurance billing.

- Health Advocate, a Pennsylvania-based company, helps consumers find the right doctor for their ailments, work with insurance companies on coverage, and manage other administrative headaches. This service helps consumers, via call centers, who are being given more responsibility to navigate the world of health care and health coverage.[34]

Innovation in public programs

Medicare Modernization Act

The structure of the drug benefit created by the Medicare Modernization Act of 2003 (MMA) has been an unusual success, with costs coming in significantly under estimates and with strong approval among Medicare beneficiaries.[35]

The MMA created a market-based delivery system for the drug benefit. Many opponents wanted the drug benefit to be delivered like other Medicare benefits, with government deciding what products would be available and how much suppliers and providers would be paid.

Instead, Congress created a new, private sector model for delivery of this largely publicly-funded benefit. Private drug plans compete for the business of seniors, vying to offer the most generous benefit packages for the lowest costs. The result has surprised even the most optimistic observers: Average premium costs are $28 a month this year, down from the $44 expected this year when the legislation was originally passed.[36]

The competitive model is saving taxpayers hundreds of billions of dollars. The 10-year cost of the prescription drug program, originally estimated at $634 billion, has been revised to about $395 billion. The Centers for Medicare and Medicaid Services (CMS) credits competition among plan providers and consumers selecting lower-priced drugs. Health and Human Services Secretary Michael Leavitt also credits the slowing of drug cost trends and higher rebates from drug manufacturers.

In addition, more seniors are benefiting from the program. CMS estimates that the total number of Medicare beneficiaries with drug coverage now is approximately 39.5 million.[37]

This experience shows that the forces that work in the private sector to drive down costs and increase choice also can be integrated into public programs.

Satisfaction

News reports were highly critical after the launch of the drug benefit in January of 2006, particularly in switching those dually-eligible for Medicare and Medicaid to MMA drug plans. But much of the confusion was attributable to the difficulties in synchronizing

Medicare and Medicaid databases to track each of the seniors.

Today, the highest satisfaction rates with Part D are among dual-eligible patients. These beneficiaries previously received their drug coverage through Medicaid and who therefore have the most experience with traditional government-run drug coverage. More than 9 out of 10 dual-eligible enrollees say they are satisfied with their new and less-restrictive Part D coverage, and 95 percent say the coverage is working well for them, according to a study by KRC Research.[38]

Nonetheless, there are still calls for the government to "negotiate" drug prices with the plans. Yet independent experts at both the Office of the Actuary at HHS[39] and the Congressional Budget Office[40] have said that government involvement in price negotiation would *not* lead to lower costs for taxpayers. In fact, it could lead to significant restrictions in access to drugs for seniors. Further, the private plans offering Medicare drug coverage are companies with decades of experience in negotiating prices – experience the government does not have.[41]

Private plan competition in Medicare Advantage

Another success of the MMA was keeping private plans in Medicare through the Medicare Advantage Program.

Medicare Advantage gives seniors the option of receiving their health coverage through private plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), Medicare medical savings accounts (MSAs), and private fee-for-service (PFFS) plans. In addition, private special needs plans (SNPs) provide comprehensive coordinated care for beneficiaries with severe and chronic illnesses.

Because Medicare Advantage plans offer more comprehensive benefits, most MA enrollees pay less for full medical coverage than they would under traditional Medicare supplemented with individual Medigap coverage. MA plans are particularly attractive to those who do not have other sources of supplemental coverage and are more sensitive to price.[42] As a result, seniors with the most limited resources have been most attracted to the broader coverage and more predictable costs of MA plans.

In 2008, Medicare Advantage enrollees received basic prescription drug coverage at a lower cost than stand-alone Part D plans. For basic coverage, MA plan drug premiums were, on average, about $6 less than average prescription drug plan premiums for basic coverage.[43] Many Medicare beneficiaries have the option of enrolling in MA plans that provide a drug benefit at no extra cost.

While MMA boosted payments for MA plans, it also provides more than $1,000 a year in added health services to the average beneficiary enrolled, or an average of $96 a month over standard Medicare coverage.[44]

The MMA also offers new incentives for private plans to provide health care to Medicare beneficiaries with serious and chronic illnesses through Special Needs Plans. Special Needs Plans provide specialized care for patients with severe and chronic illnesses, including diabetes, mental disorders, congestive heart failure, and HIV/AIDS.[45] Many SNP patients are eligible for both Medicare and Medicaid, and some are institutionalized. Similar to other types of plans, SNPs receive risk-adjusted payments to ensure that the greater health needs of these patients are met.

Enrollment in all private Medicare health plans has now reached an all-time high of more than 10 million beneficiaries, up from 5.3 million in 2003,[46] and the percentage of beneficiaries who have chosen Medicare Advantage has grown from 12.1 percent of all Medicare beneficiaries in 2004 to 20 percent in 2008.[47]

Now, seniors who rely on these plans once again risk losing their source of more comprehensive medical and drug coverage as Congress threatens to cut payments to Medicare Advantage.[48]

Medicaid and SCHIP

Many patients on Medicaid and SCHIP find they have an extremely difficult time finding a private physician who will see them because reimbursement rates are so low in many states. As a result, Medicaid recipients often are forced to get care in crowded hospital emergency rooms, depriving them of continuity of care. Giving Medicaid patients more choices of care and coverage would allow them to have the dignity of private coverage.

The Deficit Reduction Act, enacted in early 2006, provided new flexibility to the states in designing their Medicaid program. As a result, governors have been policy entrepreneurs. For example, in Indiana, Gov. Mitch Daniels has created a new program that allows the uninsured to obtain coverage in a model that looks like an HSA.[49] In Oklahoma, Gov. Brad Henry has helped the uninsured and low-income workers purchase private health coverage with Medicaid dollars.

The Medicaid Commission on which I served provided a number of recommendations about modernizing this program so it can be more responsive to patients and more financially sustainable for the future.[50]

Unfinished agendas

I commend you and the many other members of Congress who are working to expand access to health coverage for the uninsured, modernize our health care delivery system, and provide relief for private and public payers to rising health costs.

The challenges are enormous. Health costs are expected to double by 2017.[51] The costs of public programs threaten to squeeze out other public services provided by federal and

state governments. Millions of Baby Boomers are aging into Medicare, putting new pressures on the system. Millions of people continue to lose their health insurance when they lose or change jobs. There is a growing need for electronic medical records and better chronic care management, and more incentives are needed for people to purchase long-term care coverage. These are all huge challenges to tackle.

The path forward

Addressing the health care needs of 300 million Americans for better quality at more affordable prices requires modernizing our health sector to become more efficient and innovative. It is not possible to expect that one piece of legislation could be written carefully enough to accommodate these needs and also continue to provide a platform for future innovation to enhance the quality of medical care in the future.

While we face major problems with cost and access to coverage, the evidence shows that careful reform that respects the diverse needs of our population is crucial. As the examples I have offered here show, competition can work in public and private programs and force the system to be more responsive to consumers. By properly structuring incentives and creating a climate friendly to this innovation, Congress could put us on a path to uniquely American health care solutions. As I believe the evidence shows, competition works, even in health care.

Grace-Marie Turner is president of the Galen Institute, a non-profit research organization focusing on free market ideas for health reform. She can be reached at gracemarie@galen.org *She gratefully acknowledges the assistance of Research Director Tara Persico in preparing this report.*

ENDNOTES

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[4] PPO: Preferred Provider Organization
POS: Point of Service Organization
MCO: Managed Care Organization
HMO: Health Maintenance Organization
HSA: Health Savings Account
HRA: Health Reimbursement Account
FSA: Flexible Spending Account

FFS: Fee-For-Service

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