

Governor Richardson's Health Care Plan: Enslaving Physicians and Destroying Private Health Care

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By Linda Gorman

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Because of the tremendous importance of health care in New Mexicans' daily lives and to the state economy, the Rio Grande Foundation has published a series of studies on the topic of health care and proposed reforms.

These studies have analyzed the "Health Security Act," which would set up a single-payer, government-run, health care system in New Mexico, and a second study set forth a few market-based ideas for reforming health care in New Mexico. Both studies are available on the Rio Grande Foundation website www.riograndefoundation.org along with additional health care analysis.

This study analyzes Governor Richardson's proposed "Health Solutions New Mexico," proposal which the Governor has made his top priority for 2008.

The plan promises "universal health care." When tried in other places, plans with similar characteristics have provided less health care at much higher costs. This paper explains why such plans have failed, and how Healthy Solutions will harm the people of New Mexico.

In 2003, Maine's governor pushed for and passed a health reform plan that has many of the characteristics of Governor Richardson's plan. Its cost and savings projections were done by the same firm, Mathematica Policy Research that New Mexico hired to analyze several options here in New Mexico.

The results from Maine suggest that the estimates for the New Mexico plan are grossly optimistic. In Maine, costs were greatly underestimated and predicted savings failed to materialize. Taxes have been increased to support the program. The number of uninsured has been reduced by no more than 10 percent.¹ Tarren Bragdon, a health care analyst with the Maine Heritage Policy Center, estimates that the cost of insuring one additional person was almost \$16,000 dollars.²

Rather than subjecting New Mexico's citizens to new twists on old policies that have failed again and again, New Mexico's legislature should seek to protect its citizens from agenda drive reform by enacting reforms that allow the expansion of consumer-directed account-based health care. In 2007, a respected census of consumer-directed health insurance products estimated that such plans had

¹ Debra Lipson *et al.* November 2007. *Leading the Way? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms, Final Report.* Washington, DC, Mathematica Policy Research, Inc.

² Tarren Bragdon. January 30, 2006. "Challenges for Dirigo Health in 2006," *DirigoWatch*, Maine Heritage Policy Center, Portland, Maine. 3,1, p. 3.

covered 272,930 previously uninsured households at no cost to the taxpayer since their inception in January 2004.³ The Rio Grande Foundation outlined several options available for New Mexico policymakers in “Cutting Costs and Improving Health Care in New Mexico” which is available on the organization’s website.

Because Governor Richardson’s plan is even more restrictive than the Maine plan, it has a greater ability to do harm. Because it would empower bureaucrats to tell physicians how to practice medicine and control the price they can charge for their services, it is likely that physicians will leave New Mexico to practice elsewhere. Getting good medical care is impossible if no one is willing to provide it at a price the bureaucrats allow patients to pay.

Specific problems with the plan include:

Bureaucrats will tell physicians how to treat their patients.

1. Prices that can be paid for medical services in New Mexico would be set by bureaucrats and physicians would be forced to accept “any state funded public source of payment for eligible individuals” as a condition of licensure. Nothing could force doctors out of New Mexico faster than forcing price controls on *all* doctors who wish to practice in the state;
2. Performance measurements would be used to pay physicians. Those measures have not been adequately studied. In some cases, seemingly reasonable performance measures have harmed patients. For example, surgeons who are graded on outcomes fear that their average grade will fall and their incomes will be affected if they report higher mortality rates. They adjust by telling the sickest patients that nothing can be done for them.

Payments for certain kinds of care also make physicians less likely to act in the best interests of a patient if his needs are different than those designed for the population average that is enshrined in bureaucratically accepted best practices. This is a particular problem in prescribing, because bureaucracies often pressure physicians to prescribe the cheapest drug for a given condition even though a patient might be better off with a more expensive drug with a better side effect profile;

3. Require that physicians accept commercial insurance rates as payment in full regardless of whether or not those rates are fair;
4. Require that physicians use electronic medical records even though their ability to lower cost or improve care remains in doubt due to operational costs and the difficulty of correcting errors. At the Veterans Administration, where electronic recordkeeping has been widespread, input errors and errors created by electronic cutting and pasting have been a problem.

Families would be told how to order their household spending. People would be forced to buy health insurance before anything else even though items like housing, food, education, and reliable transportation are more important to many people than health insurance.

³ AHIP Center for Research and Policy. April 2007. *January 2007 Census Shows 4.5 Million People Covered by HAS/High-Deductible Health Plans*, p 5.

Everyone with an annual household income above 400 percent of the federal poverty level (currently \$40,840 for one person, \$54,760 for two people, and \$82,600 for a family of 4), and children in households with incomes under 300 percent of the federal poverty level (\$40,170 for two, \$61,950 for four) will have to have health insurance coverage, regardless of financial circumstances by 2010. According to national statistics, in 2006 about 23 percent of the uninsured were in households with annual incomes over \$50,000. About 8.5 percent of the uninsured were in households with incomes over \$75,000.

New Mexico already makes a guaranteed issue insurance product available at rates that are affordable to people in the income groups that the Governor's plan focuses on. In view of these data, one might characterize the plan as a solution in search of a problem.⁴ Problems with this kind of meddling might include:

1. A need for government permission in order for people to reorganize their household spending. In Massachusetts, people who fall on hard times have to request a 13 page Certificate of Exemption in order to legally cancel their policies;
2. New Mexicans will face a large "health insurance tax" if they increase their incomes from 399 percent of the federal poverty level to 401 percent of the federal poverty level. Some people may decide to work less and enjoy more free time to avoid the extra income, thus lowering the taxes they pay and increasing their use of taxpayer subsidies;
3. This coverage requirement will be enforced by requiring proof of coverage at licensure, school and university enrollment, tax filings, and on job applications. Because income varies, this means that the state will somehow have to track incomes;
4. Employers will be required to "collect information about coverage" on employees who do not purchase employer provided health insurance. Such intrusion will be burdensome and uncomfortable for both parties;
5. In Massachusetts, the only state that has passed an individual insurance mandate, costs are rapidly exceeding projections. There is no evidence that people are getting more or better health care, in part because those enrolled in public programs cannot find physicians willing to see them;⁵
5. Bureaucracies like the Health Coverage Authority have historically been hostile towards those who prefer to pay cash for most medical care services and those who prefer insurance policies with large deductibles. This increases costs, as using third party payments to buy health care is the most expensive way to do it;
6. Employers would be forced to provide health insurance whether or not it makes business sense to do so and whether or not their workers would rather have less expensive individual policies and higher wages;

⁴ Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica Smith. 2007. U.S. Census Bureau, Current Population Reports P60-233, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Washington, DC.

⁵ Alice Dembner. November 18, 2007. "Success could put health plan in the red,"

7. The plan requires electronic health records which make people more likely to suffer identity theft. To date, there is no known method for securing individual medical records against improper use.

It tells insurance companies will be told how to run their businesses.

1. The plan would require that insurers pay at least 85 percent of their revenues on direct medical benefits. This means that insurers that do a good job of minimizing costs, funding future liabilities, improving customer service, limiting fraud, and finding ways to provide better treatment for less cannot be rewarded with higher profits. It is a “spend whether you need to or not” recipe for higher health care costs;
2. Insurers in New Mexico’s individual market will be required to issue policies to everyone regardless of health status. In the other states that have mandated guaranteed issue by all insurers, premium prices have increased, the number of insurers has been reduced, and innovation has halted. Why this is necessary is unclear because, as previously mentioned, New Mexico already has guaranteed issue for individuals via the New Mexico Medical Insurance Pool. Everyone in New Mexico can get health insurance regardless of underlying conditions;
3. The plan halves the allowable amount on small group rate renewal increases, reducing it from 20 percent to 10 percent. According to Aon Consulting, this is below the average trend of medical care price increases in the United States of 13 to 20 percent in the last decade.⁶ Such unreasonable limits on price increases ensure that insurers will either reduce service dramatically or leave New Mexico entirely;
4. Information technology requirements will be dictated to insurers.

Health care would be made more expensive.

1. Employers would be required to either contribute to employee health insurance premiums or pay a new per employee tax, also known as a fee, for workforce development measures of dubious worth. For example, a 2005 report to the New Mexico Legislative Finance Committee concluded that funding designed to increase nursing graduates produced disappointing results;
2. Employers would be required to create a pre-tax health insurance plan. Although this is said to be “low-cost,” the Massachusetts Connector Authority Section 125 Plan Handbook for Employers is 64 pages long⁷;

⁶ Aon Employee Benefits Consulting, “Health Care Trend Survey,” Spring 2006, http://www.aon.com/us/busi/hc_consulting/employee_benefits_cons/health_welfare/articles/spring_2006_healthcare.pdf

⁷ State of Massachusetts, “Section 125 Plan Handbook for Employers,” July 1, 2007, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Section%2520125%2520Handbook%2520documents/Section%2520125%2520Handbook.pdf>.

3. Extensive development of electronic data information systems would be mandated without careful consideration of their costs relative to their benefits.

It creates new bureaucracies to fix the problems created by the existing Medicare and Medicaid bureaucracies.

In campaigning for President, Governor Richardson has stated that he is against creating any new health bureaucracies.⁸ In New Mexico, on the other hand, Richardson's health care plan would create new bureaucracies all over the place. In addition to the Health Care Coverage Authority, a super regulatory body that will control everything from the prices physicians can charge to the content of your insurance policy, Governor Richardson wants New Mexico taxpayers to fund:

- A transitional advisory group—to advise on creating the Health Care Coverage Authority
- The Native American Health Care Council
- The Delivery System Policy Council
- The Cost Containment and Finance Council.
- The Benefits and Services Council
- The Health Policy and Research Division
- The Plan Management Division
- The Outreach and Education Division
- The Administrative Services Division

To get an idea of what this will cost, the tab for the existing 22 person Health Policy Commission, which basically repackages standards and data created by others, spent \$1.2 million all by itself in 2007. In view of the huge cost overruns in Maine, the cut in the cost projections from \$333 million to \$72 million over five years by the consulting firm Mathematica, should be viewed as politically expedient.⁹

Similar policies have failed everywhere they have been tried. What have the people of New Mexico done to deserve having such misguided reforms inflicted on them?



About the Author

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⁸ Robynn Tysver. August 7, 2007. "Richardson unveils health care plan in Council Bluffs," *Omaha World-Herald* (NE), via eLibrary accessed January 6, 2008.

⁹ Winthrop Quigley, "Health Proposal's Cost Lowered: Math Error Faulted For High Estimate," *Albuquerque Journal*, December 19, 2007, http://www.healthdecisions.org/HealthPlans/News/default.aspx?doc_id=145526.