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Who owns your health?

Minnesota doesn't rank so well in study of states' "health ownership"

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Debates over health care policy typically focus on how to control costs and expand the number of people with health insurance. But does anyone keep track of how well state laws let people control their own use of health care dollars?

One person who does is John R. Graham, who has constructed the U.S. Index of Health Ownership. The index, described in a report of the same name, ranks states according to how well their policy respects personal ownership of health and health care. Graham, formerly a management consultant, writes and speaks on health care reform for the Pacific Research Institute (www.pacificresearch.org), a San Francisco-based free-market think tank. Graham is PRI's director of health care policy studies, and is also a contributor to the website State House Call (www.statehousecall.org), where I serve as editor.

Graham defines "health ownership" as "the degree to which Americans are still free to engage health resources as they prefer, free from undue state interference." The index, in turn, "is meant to facilitate citizens' understanding of these burdens on their freedom to engage health resources."

Health ownership applies to both consumers and providers of health care and insurance. Can you buy the kind of insurance policy you want, or are your options severely limited by law? May a group of doctors own and operate a freestanding surgical center, or are they prevented from doing so by law?

Some laws promote health ownership while others inhibit it. Graham cites Duke University professor Christopher J.Conover, who estimates that federal regulations (particularly HIPAA), "have a net benefit" for health ownership. On the other hand, state regulations, which are the focus of Graham's index, reduce health ownership.

The report lays out four dimensions of ownership. The first judges state Medicaid programs. Do they encourage accountability to state taxpayers, or do they shift responsibility to other states through drawing excessively on federal matching funds? Do they make it easy for people to enroll in Medicaid, thereby decreasing personal

ownership and increasing dependency on government? Does a state's program wisely manage its limited dollars?

The second dimension is the private health insurance market. States get dinged for regulations that "cause people to become uninsured" through regulations that drive up premium costs. Higher costs, in turn, make it more difficult for people to obtain insurance on their own. As with other dimensions of the index, the insurance market is measured by six variables. These include community rating requirements and mandated benefits, as well as the percentage of uninsured people and the qualities of the state's high-risk pool (if any).

The third dimension is the legal climate. Have tort reforms placed caps on damages? Has the state placed restrictions on who can serve as an expert witness? Graham concedes that such limits appear "offensive to liberty." But he scores them as contributing to health ownership, on the ground that they make health care and health insurance more affordable through reducing the costs of defensive medicine.

The fourth dimension doesn't get nearly as much play in the health care debate as it should. It is the extent to which laws and regulations prevent health care providers from being entrepreneurs who can offer new services or opening new facilities. There are many such restrictions, including scope of practice laws, bans on physician ownership of hospitals and certificate of need laws. Together and by themselves, these rules restrict who practices medicine and how they do it. They all have their rationales, but they inhibit the liberty of medical professionals and patients to engage in commerce as they see fit. The latest example of such restrictions are staffing requirements for convenience clinics, which offer a limited range of services for a set price.

The Rankings

According to Graham, the top five states for respecting health ownership are Alabama, Montana, Nebraska, North Dakota and New Hampshire. Alabama gets high marks for having a lightly regulated insurance market, modest government programs and giving providers more room to work.

The bottom-ranking states include North Carolina, Vermont, Rhode Island, Massachusetts, and in last place, New York. New York "suffers from government health programs that are out of control, a grossly overregulated private insurance market, and almost completely uncompetitive provider markets."

Minnesota scores a below-average 38, though its rankings on the specific dimensions vary. It scores a 49 in government health care, since it "suffers from extremely high Medicaid eligibility, poor innovation through [Medicaid] waivers, freeloading on federal taxpayers, and inadequate investment in prescriptions for its Medicaid population."

Minnesota scores higher on the private health insurance category, at 17, even though it has more mandated benefits (62) than any other state. It comes in at 12 in the medical tort category.

For being a state with a leader in convenience clinics (MinuteClinic, a national company, is based in Minneapolis), it does surprisingly poor (20) on the “state provider burden of regulation” category.

It’s easy to be fixated on the goal of making sure that everyone is healthy, or even the proximate goal of health insurance. But we need to respect the health of our political heritage, too. The difference between a free people and one that’s not free is not merely the absence or presence of elections. A free people live in a country in which government leaves them room to make decisions that affect their own lives.

And few things are more personal than your health.