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The Best and Worst Ideas for Health Care Reform

As politicians confront the difficult task of health care reform, they face a dizzying array of reform plans. In fact, there are so many plans that most policy analysts have ceased trying to keep track of them.

Yet the vast majority of all plans — both good and bad — are based on a few simple ideas. This backgrounder provides a brief summary.

Two Competing Visions

"Most reform plans are based on a few simple ideas."

One reason why health care debates rarely resolve anything is that the debaters often rely on diametrically opposed assumptions — assumptions that are rarely disclosed. Those who hold a "bureaucratic" vision of health care invariably talk of "needs" and "resources." Many of them do not have the word "individual" in their vocabulary.

Those who hold an "individualistic" vision of health care know that all behavior is individual behavior. For the most part, behind every serious social problem is a system of distorted incentives. The individualistic vision leads one to identify and eliminate these distortions. The bureaucratic vision leads one to expand and multiply them.

Individuals vs. Bureaucracies. When forced to confront the reality of individual choice and behavior, those who hold a bureaucratic vision of health care invariably point to unconscious patients in hospital emergency rooms — arguing that choice is impossible. They conveniently ignore the fact that 80 percent of all procedures are probably "elective" and that in the vast majority of cases, patients have ample opportunity to reflect and choose.

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It would be a mistake, however, to conclude that the bureaucratic vision cannot see past the hospital emergency room. The issue is much deeper and more profound. Those who hold the bureaucratic vision are fundamentally anti-individual and anti-choice. They oppose individual empowerment on principle.

Three Assumptions Behind the Worst Health Care Reform Proposals. Behind the bureaucratic vision of health care are three bad assumptions. To one degree or another, they are responsible for most unworkable reform proposals. They are:

- No one — especially not patients, but preferably not even physicians or hospital personnel — should be forced to choose between health care and other uses of money.
- Insurance premiums (or tax prices) should never reflect individual health risks.
- Decisions by bureaucracies are always better than decisions by individuals.

When a health care system is based on these assumptions, social problems are inevitable. To the degree that patients perceive health care as free, they will overconsume health care resources. If insurance prices do not reflect real risks, some people will be overcharged and others will be undercharged. Those who are undercharged will overinsure (or demand more insurance from their employer or through the political system). Those who are overcharged will tend to be underinsured. When power is concentrated in the hands of bureaucracies, individual incentives are distorted in hundreds of ways, and people find it in their self-interest to take actions that defeat legitimate social goals.

"Those who have a bureaucratic vision of health care are fundamentally anti-individual and anti-choice."

Three Assumptions Behind the Best Health Care Reform Proposals. The individualistic vision of health care recognizes that we will get better outcomes in the long run if people bear the costs of their bad decisions and reap the benefits of their good ones. On the whole, good incentives for individuals lead to good social outcomes. Accordingly:

- Since society as a whole must choose between health care and other uses of money, as often as possible those choices should be made by individual patients.
- Although society as a whole may choose to subsidize the less fortunate, most people should pay the real cost of what they get — in medical care and in health insurance.
- Ideal institutions are ones that make social goals consistent with the self-interested behavior of individuals.

Reform proposals based on these assumptions are likely to lead to an improvement in our health care system. Reform proposals that reject these assumptions are likely to make our health crisis worse, regardless of the particulars.

The United States vs. Other Developed Countries. The three assumptions underlying the bureaucratic view of health care have been fully accepted and institutionalized in every other developed country. Yet they are not an anomaly in our own. In fact, these three assumptions formed the basis for the original Blue Cross-Blue Shield vision and shaped the development of our largely private health insurance system:[1]

- Blue Cross believed that anyone who had a health insurance deductible or copayment requirement was underinsured and that the ideal policy was first-dollar coverage for all medical expenses.

- Blue Cross believed that everyone should be charged the same price for health insurance — regardless of any indicator of health risk.

"Whereas other countries chose public sector socialism, we chose private sector socialism."

Whereas other countries chose public sector socialism, the United States chose private sector socialism. The mechanisms were different, but the ideals were the same.

Indeed, one reason why the United States is perceived to have greater health policy problems than most other countries is that to a large extent we have been more successful than others in implementing a system based on the three bad assumptions. Virtually every major corporation in America has institutionalized the system of community rating originally favored by Blue Cross.[2] And ours is the only country in which people can freely enter the medical marketplace, consume every service from an MRI scan to a cholesterol test and have most of the bill paid by someone else.

Health Insurance Reform

Serious problems exist in the market for private health insurance. Among them: (1) policyholders find that after they get sick their insurance can be canceled or they can face unreasonable premium increases; (2) employees find that when they leave employment they lose insurance coverage, even if they have a medical problem; and (3) people with medical problems who once lose coverage may find that no other insurer will insure them.[3]

Good Idea: Guaranteed Renewability and Portability. Most of the problems in the market for private health insurance do not exist in the market for life insurance, which can easily be taken as a model. Once a person becomes insured, health insurers should be required to continue to offer coverage in the future at reasonable prices. Moreover, any employer who takes advantage of the

tax subsidy for employer-provided health insurance should make the benefit personal and portable — so that employees take their health insurance with them if they leave the firm. Companies that self-insure should be required to buy a conversion policy for each employee.

"Health insurance should function like life insurance — guaranteed renewable at reasonable prices."

Good Idea: Direct Subsidies for Low-income People Who Are Uninsurable. An ideal insurance market is one in which risk is priced accurately. Each person entering an insurance pool is charged a premium that reflects the expected cost and risk that person brings to the pool. Put another way, in an ideal insurance market, people pay for what they get.

If policies were guaranteed renewable and portable, people would have strong incentives to become insured before they got sick. But what about people today who are already sick and uninsured and who are generally thought to be "uninsurable"?

The best approach is to subsidize these people directly, making the amount of subsidy highest for those with lowest incomes. The subsidies should be funded by general taxes. One method is for government to pay for a portion of their medical bills. Another method is for government to pay part of the cost of having an insurer manage their health care. The least attractive option is to subsidize premiums for these people to join a risk pool.[4] But even this option is much better than those discussed below.

Bad Idea: Guaranteed Issue. A number of reform proposals would force insurers to sell policies at fixed prices to people — no matter how sick or how well they are. Under these proposals, insurers would be forced to overcharge low-risk people in order to undercharge high-risk (sick) people.[5]

Ironically, this reform is supported by some large health insurers, small business groups (including the National Federation of Independent Businesses) and medical associations — groups that would almost certainly be worse off in the long run if the proposal were adopted.[6]

"Why buy health insurance today if you know you can buy it after you get sick?"

Whereas guaranteed renewability would encourage people to purchase health insurance (because they would be confident that once sick, they would be able to continue coverage at reasonable rates), guaranteed issue has the opposite effect. Why buy health insurance today if you know you can buy it after you get sick?

According to one estimate, only 1 percent of Americans under the age of 65 are uninsurable.[7] Yet in an attempt to make health insurance more affordable for this 1 percent, guaranteed-issue reforms would impose price controls and raise premiums for the other 99 percent. The result would almost certainly be a larger number of people who are voluntarily uninsured.

Contrary to widespread impressions, most of the 34 to 35 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age and in the healthiest population age groups.[8] They have below-average incomes and few assets. As a result, they tend to be very sensitive to premium prices. Moreover, the primary reason why most of them are uninsured is that they have judged the price too high relative to the benefits. Very few have been denied coverage.

The artificial premium increases that would result from many health insurance reform proposals would substantially increase the number of employers who fail to provide coverage for their employees and the number of individuals who are uninsured by choice.

Worst Idea: Community Rating With No Waiting Period. An extreme form of guaranteed issue is community rating. This idea has been endorsed by President Bush, who has announced that sick people should be able to obtain health insurance for the same price as healthy people.[9] Under the Bush proposal:

- A person with AIDS would be able to purchase health insurance for the same price as someone who does not have AIDS.
- People in hospital cancer wards would be able to buy health insurance for the same price as people who do not have cancer.

"Under the Bush proposal, people could buy health insurance as they enter a hospital and drop their coverage as they leave."

George Bush is not the first person to propose charging the healthy and the sick the same premium for health insurance. Community rating is about to be implemented in Vermont, and variations on that idea are under consideration in a dozen states. The only important difference among the proposals is the ease with which sick people can enter a pool and healthy people can leave.

Most proposals give healthy people at least some incentives to buy health insurance. For example, a typical provision is that preexisting conditions are not covered until after a 12-month waiting period. Thus people who purchase insurance *after* an illness occurs risk 12 months of medical bills before the insurer starts paying the tab. The Bush proposal, by contrast, has no waiting period.

Page 22 of the president's "white paper" on health care reform policy proposes that hospitals be able to get patients insured the moment they enter the emergency room. Uninsured people would face no financial risk. They could get insurance coverage as they enter a hospital and drop it as they leave.[10] Apparently the White House failed to consider that under such a system only sick people would buy health insurance.

Controlling Health Care Costs

Health care spending in the United States has been increasing at almost twice the rate of increase of our gross national product (GNP). If this trend continues, by the middle of the next century we will be spending all of our GNP on health care.

Both common sense and empirical studies confirm the reason for the dilemma. Most of the time when we enter the medical marketplace as patients, we are spending someone else's money rather than our own:[11]

- Every time we spend $1 at a hospital, we pay less than 5 cents out of our own pocket.
- Every time we spend $1 at a physician's office, we pay less than 19 cents out of our own pocket.
- For health care of all types, we pay less than 25 cents of our own money every time we spend $1 on medical care.

What should be done?

"Families can save a great deal of money by choosing higher deductibles."

Good Idea: Medical Savings Accounts.[12] That Americans are overinsured is no accident. Federal tax law excludes employer health insurance premiums from employee income — a generous subsidy that means government is effectively paying half the cost of health insurance for many workers. On the other hand, if employers and their employees choose high deductible policies and place the premium savings in an account from which to pay small medical bills, government takes up to half of the savings in taxes and also taxes any interest earned on the remaining balance. Without the distorting effects of the tax law, families can save a great deal of money by simply choosing high-deductible health insurance:

- If a family in a city with average health care costs increases its deductible from $250 to $1,000, its premium savings will be $1,315 — almost twice the amount of the increase in the deductible.[13]
- If the family increases its deductible from $250 to $2,500, it will save $1,749 in reduced premiums — roughly equal to the amount of coverage the family would forego, considering the effects of the deductibles and copayment.[14]

To take advantage of these opportunities, people should be allowed to choose high-deductible policies and to deposit the premium savings in a Medical Savings Account (MSA).[15] As in Individual Retirement Accounts (IRAs), funds in MSAs would grow tax free. At the end of a person's working life, the funds could be rolled over into an IRA or pension fund or used to purchase postretirement health care.

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Exhibit I

Ten Advantages of Medical Savings Accounts

Saving Money. When people purchased medical care with funds in an MSA, they would be spending their own money rather than someone else's money. As a result, they would become careful, prudent customers in the medical marketplace.

Restoring the Doctor-Patient Relationship. Bureaucratic efforts to control costs are increasingly interfering with the doctor-patient relationship. With MSAs, patients and doctors would be encouraged to manage their own care — and would probably do a much better job.

Maintaining The Quality of Care. Bureaucratic efforts to reduce costs are also threatening the quality of patient care. To the degree that patients are spending their own money, patients and doctors will make the decisions.

Encouraging Rationing by Choice. Unless someone makes the difficult choice between medical care and other uses of money, we will be spending the entire GNP on health care. MSAs allow individuals and families — rather than large, impersonal bureaucracies — to make those decisions.

Creating a Competitive Marketplace. Most patients cannot discover the price of even routine procedures before entering a hospital and cannot read the bill when they are discharged. But patients spending their own money would quickly force radical change. In the market for cosmetic surgery and for surgery performed in the private sector in England, a single package price announced in advance is the norm.

Providing Funds for Preventive Care. MSAs would provide a source of funds for services not covered by health insurance.

Providing Funds for Health Insurance Premiums. MSAs would provide a source of funds to continue health insurance coverage when people are unemployed.

Providing Funds for Long-Term Care. MSA funds not spent during a person's working years would be available for long-term care, long-term care insurance and other postretirement medical needs not met by Medicare.

Creating Real Insurance. With MSAs, health insurance would likely return to its traditional function — payment for risky, unforeseen, costly medical episodes — and many of the problems in the health insurance marketplace would disappear.

Creating Personal and Portable Benefits. MSAs would be the private property of the individual account holder. Their establishment would be a movement in the direction of a worthwhile social goal: making all employee benefits personal and portable.

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

The creation of Medical Savings Accounts would radically transform the U.S. health care system. [See Exhibit I.] It is for this reason that MSAs are supported by a broad coalition of think tanks,[16] the American Medical Association, the American Farm Bureau, the National Association of the Self-Employed, the National Association of Health Underwriters and even many insurance companies.

Good Idea, But ... : Government as the Insurer of Last Resort. In the 1970s, a U.S. Treasury report recommended abolishing all tax deductions for health insurance and medical expenses.[17] The federal government would save so much money that (with no extra cost to government) it could become the insurer of last resort for everyone — paying all medical bills that exceeded 10 percent of household income.[18] Variations on this idea have been proposed by Martin Feldstein (former chairman of the President's Council of Economic Advisors) and Nobel Laureate Milton Friedman.[19]

The proposal has a number of attractive features. Everyone would be protected against catastrophic losses due to high medical expenses. In any given year, the vast majority of people would pay their own medical expenses — an excellent incentive to shop prudently in the medical marketplace. Government would be involved in paying medical bills for a relatively small number of people — probably 5 percent or less of the whole population.

The downside of this proposal is that it could easily lead to political pressure for rapid expansion of government's role. Ten percent of the income for a $30,000-a-year family is equal to $3,000. Thus, the family would have government-backed catastrophic insurance with a $3,000 deductible. Almost certainly, there would be political pressure to lower the deductible to $2,000, then $1,000, etc. National catastrophic health insurance could easily turn into garden variety national health insurance, with first-dollar coverage for everyone.

"The Heritage plan would encourage people to overconsume in the medical marketplace."

Bad Idea: Deductions for Out-of-Pocket Expenditures. The Heritage Foundation has argued that the tax law distorts our choices by making employer-provided health insurance premiums tax free and by giving no tax deduction for out-of-pocket expenses.[20] Heritage argues that if out-of-pocket expenses received just as much tax encouragement as health insurance, people would choose high deductibles and self-insure for small medical bills. There are four problems with this argument.

First, even if the tax law treated both options equally, health insurance would still be more attractive. The reason is that health insurance premiums would be deductible each year, whereas savings for future medical expenses would not be. For example, Exhibit II illustrates an individual who has the option of purchasing $100 of additional insurance or self-insuring. A medical bill of $180 is incurred in the second year. As the exhibit shows:

- The option to self-insure and pay medical expenses directly requires 20 percent more pretax income than the purchase of insurance.[21]

- If the example were altered to allow the medical expense to occur in the fourth year, buying health care directly would require almost 50 percent more pretax income.[22]

- Third-party insurance is more attractive under this scheme, even though administrative costs consume 10 percent of the premiums.

A second problem is that once people become sick, a deduction (or tax credit) for medical expenses simply encourages them to spend more. Under the Heritage plan, it is entirely possible (even likely) that total health care spending would be higher than under the current system.

A third problem is that the Heritage plan invites massive government involvement in the health care system. Whereas the Treasury plan (described above) would make government a copayer for only a few medical bills incurred by a small number of people, the Heritage plan would make government a copayer for every patient and every medical bill. The temptation would be strong for government to impose on the entire health care system what it has already imposed on the Medicare program: price fixing for every hospital procedure and every service.[23]

Finally, the Heritage plan confuses insurance with spending. The alternative to third-party insurance is not direct, out-of-pocket spending. The alternative is self-insurance (personal savings). If we want to remove the distortions in the tax law, savings — not spending — must receive the same tax encouragement as third-party insurance.[24]

Worse Idea: Price Controls. The idea that government should fix the price for third-party reimbursement is increasingly popular. Already, the federal government fixes prices for hospital services for Medicare patients[25] and it is in the process of doing the same for physicians' services.[26]

"Price fixing under Medicare is causing health care rationing."

Two things can go wrong when government arbitrarily fixes prices. If the price is set too high, it encourages overprovision. If the price is set too low, it encourages underprovision. The tendency is to set the price too low. And if price controls are viewed as a method of controlling spending, they almost certainly will become a vehicle for imposing health care rationing.

Whether intentional or not, Medicare's payment formulas are already having an effect on patients:

Exhibit II

What's Wrong With the Heritage Plan?[1]

Option 1: Buy More Health Insurance

	Year 1	Year 2	Total
Before-Tax Income Required	**$100**	**$100**	**$200**
Health Insurance Premium	**100**	**100**	**200**
Administrative Costs	**10**	**10**	**20**
Cost of Health Care	**0**	**180**	**180**

Option 2: Buy Health Care

	Year 1	Year 2	Total
Before-Tax Income Required	**$120**	**$120**	**$240**
Taxes[2]	**60**	**0**	**60**
Amount Available to Purchase Care[3]	**60**	**120**	**180**
Cost of Health Care	**0**	**180**	**180**

[1]Under the Heritage Foundation's plan, out-of-pocket expenditures would receive just as much— or more — tax encouragement as the purchase of health insurance. In this example, both expenses are simply excluded from income and the individual faces a marginal tax rate of 50 percent. Instead of an exclusion, Heritage specifically recommends a 20 percent tax credit for health insurance premiums and a 30 percent credit for out-of-pocket expenses. Under this scheme, both options would require more pretax income, but the difference between them is minor — $143 per year to purchase insurance vs. $140 to purchase care directly. Of course, if the medical expense occurs in the third or fourth year, the insurance option is definitely preferable. A different problem is created for low-income families, for whom Heritage recommends refundable tax credits. An 80 percent refundable tax credit for health insurance means that government pays 80 percent of the premium. But we would also need an 80 percent credit for out-of-pocket spending in order to make option 2 equally attractive and, say, a 90 percent credit to make it more attractive. This would leave patients paying only 10 percent of their medical bills — precisely the feature of the current system about which Heritage correctly complains. Perversely, in this example third-party insurance (with a 20 percent copayment) would have better incentives than direct purchases (with an effective 10 percent copayment).

[2]Assumes a 28 percent federal income tax, a 15.3 percent FICA tax and a 6.7 percent combined state and local income tax.

[3]Interest income is ignored in this example. However, if interest were earned on the $60 of savings in year 1, it would be taxed at a rate of 34.7 percent.

- Although hearing loss is the most prevalent chronic disability among the elderly and affects one-third of all Medicare patients, Medicare's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.[27]

- When Medicare reduced the real reimbursement rate for kidney dialysis in the 1980s, many physicians reduced the treatment time — a practice that reduced the patient's chances of survival.[28]

- A survey of 21 medical conditions for which an implanted medical device is often the indicated treatment found that for 18 of them the government's payment was well below hospital cost and in more than half the cases Medicare patients did not receive the device.[29]

Even when Medicare's reimbursement equals the average cost of treatment, price fixing discriminates against above-average-cost patients. These tend to be the sickest patients and more often than not they are low-income and non-white. For example, blacks and Hispanics have more severe illnesses, longer hospital stays and higher hospital costs than white patients, on the average.[30]

"There is no evidence that global budgets lead to greater efficiency."

Price controls are also used in the Medicaid program, where it is not uncommon for government to pay as little as 50 cents on the dollar for services for low-income patients. One consequence is that pregnant women on Medicaid are denied access to most OB/GYN physicians and often turn to hospital emergency rooms as the only alternative for prenatal care.

Very Worst Idea: Global Budgets. In most other developed countries, hospitals or area health authorities are given a fixed budget and required to deliver health care within that budget. Although the idea of living within a budget sounds reasonable on the surface, in practice "global budgeting" is simply a euphemism for health care rationing. By limiting what hospitals can spend, governments force them to ration health care.

There is considerable evidence that when health care is rationed, the principal victims are the poor, the elderly, racial minorities and people who live in rural areas. [See Exhibit III.] Moreover, there is no evidence that global budgets lead to greater efficiency. To the contrary, they almost certainly encourage inefficiency. Consider the experience of three English-speaking countries with cultures similar to our own:

Exhibit III

What's Wrong With Canada's Global Budgets?

Canada attempts to control health care spending by restricting sophisticated services to hospitals and then severely limiting hospital budgets. In most provinces, outpatient surgery is either prohibited or discouraged. In Ontario, CAT scanners and MRI scanners are restricted to hospitals by law. The results are inefficient and unfair.

Lack of Access to Technology. Unlike an American, a Canadian concerned about headaches cannot simply walk in and receive an MRI scan. Even for those patients doctors deem to be in great need, the waiting list for a brain scan in Ontario is now one year and four months. Nor can a Canadian with high cholesterol easily get a cholesterol test. In most provinces, the screening standards are much stricter than American doctors consider appropriate. One reason why gaining access to technology in Canada is difficult is that the technology isn't there.

Rationing by Waiting. There are 260,000 Canadians waiting for medical care. Patients can wait as long as five months for a Pap smear, eight months for a mammogram and more than a year for heart surgery. The Canadian press is full of stories of patients dying because they did not get surgery promptly. And, like other countries with global budgets, in Canada rationing decisions are haphazard. There is no national waiting list and no mechanism to insure that the patients in greatest need receive care first.

Unequal Access to Care. Access to care is anything but equal. For example, among the 30 health regions of British Columbia, access to physicians varies by a factor of six to one. Access to specialists varies by a factor of 12 to 1, and access to some specialties varies by a factor of 35 to 1.

Discrimination Against the Poor. As in the United States, low-income families have shorter life expectancies and higher infant mortality rates.

Discrimination Against Racial Minorities. In both the United States and Canada, Indians have shorter life expectancies than the rest of the population. However, life expectancy is five years longer for an American Indian male and six years longer for a female. Indian infant mortality is almost twice as high in Canada as in the United States.

Discrimination Against the Elderly. Health care rationing in every country tends to favor the young over the old. Canada is no exception. Per capita, the United States performs twice as many coronary artery bypass operations on elderly patients as Canada does. Among 75-year-olds, the difference between the two countries is four to one.

Sources: John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991; and Michael Walker, Fraser Institute, author communications.

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- Currently the number of people waiting for surgery totals more than one million in Britain,[31] 50,000 in New Zealand[32] and 260,000 in Canada.[33]

- Although those waiting represent a small percent of the total population (1 to 2 percent), they probably represent a large portion of those who need access to modern medical technology.[34]

- Yet in spite of the lengthy waiting lists, at any one time about one-fifth of all hospital beds are empty in all three countries and another one-fourth are being used as an expensive nursing home by nonacute elderly patients.[35]

Eliminating Waste

Joseph Califano, former Secretary of Health, Education and Welfare (now the Department of Health and Human Services) estimates that one out of every four dollars spent in our health care system is wasted.[36] Robert Brook of the Rand Corporation maintains that "perhaps one-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without."[37]

No one doubts that there is a great deal of waste. But like waste in government, waste in health care is not tagged for easy identification. What is wasteful to one person is not necessarily wasteful to another. And waste has its own constituency.

"With competitive markets, 250 million Americans would have a self-interest in eliminating waste."

Good Idea: Use Markets. Virtually the entire world has come to realize that markets are powerful tools for encouraging efficiency. With competitive markets, 250 million Americans would have a self-interest in eliminating waste. Buyers would patronize low-cost providers. Providers would search for low-cost methods of delivering services. As noted above, creating Medical Savings Accounts and empowering patients is probably the single best step in the direction of encouraging market-based solutions.

Mediocre Idea: Managed Care. In the context of competitive markets, many of the techniques developed by the managed care bureaucracy might prove useful. Clearinghouses for information on prices and quality could be a valuable aid to patients. Computerized protocols (discussed below) could be a valuable tool for physicians. With greater information at their disposal, patients and physicians could manage their own care.

What "managed care" means to many people, however, is not an aid to competitive markets but a substitute for them. All too often, the managed care bureaucracy envisions a world in which the managers have one set of goals, while 250 million patients and physicians have different goals. This private sector socialism would have many of the same defects as public sector socialism.

With respect to small dollar items — from blood tests to CAT scans — it is doubtful that managed care can reduce costs at all, let alone eliminate waste. The cost of managing these expenditures is probably higher than any benefit to be derived. And imposing arbitrary rules introduces the risk of mistakes that would lead to expensive tort liability lawsuits. With respect to high-dollar items, managed care has had some successes. But the most impressive gains are occurring when the managers use markets rather than try to replace them.[38]

Worst Idea: Computerized Protocols. Researchers at the Rand Corporation want to develop computerized protocols for every medical procedure. They frankly admit that this computerized version of "cookbook medicine" could be used to tell doctors how to practice and even how to ration health care.[39] In tests so far, physicians using their own judgment have outperformed the computer programs.[40] That is not surprising. Medicine is still more an art than a science. And given the speed with which medical knowledge is emerging, there is no reason to suppose that computer programmers can work quickly enough to keep up with it.

"Computer programs could be used to dictate medical practice and ration health care."

Computer programs could prove a valuable aid to patients and physicians in some circumstances. The danger is that computerized protocols also could be used as Rand researchers suggest they might be: to deny patients access to medical procedures and to ration health care.

Insuring the Uninsured

In any one month, about 34 to 35 million people are uninsured, and the number appears to have increased over the past decade.[41] This is not a stable population, however. Although many people become uninsured during their lifetimes, very few remain in that status for long periods of time. Only 30 percent of the uninsured stay uninsured for more than one year, and only 4 percent of the nonelderly population stays uninsured for much longer than two years.[42]

Why are so many people temporarily uninsured? The evidence suggests three reasons. First, the constraints of federal tax law and employee benefits law have made it increasingly difficult for small businesses to provide health insurance for employees. Second, although the federal tax law generously subsidizes employer-provided health insurance, there are few or no subsidies for individuals who purchase their own health insurance. Finally, state regulations are increasingly pricing lower-income, healthy people out of the market for health insurance. [See the discussion below.] Interestingly, only 1 percent of the nonelderly population is unable to buy health insurance because of current medical problems.[43]

"Higher taxes paid by the underinsured should be recycled back to county hospitals."

Good Idea: Tax Credits and a Real Safety Net. Under the current system, employer-provided health insurance escapes, say, a 28 percent income tax, a 15.3 percent FICA tax and a 4, 5 or 6 percent combined state and local income tax. This means that government is effectively paying half of the premium for people fortunate enough to be able to "purchase" health insurance through an employer. On the other hand, people who purchase their own health insurance must pay taxes first and pay for their insurance with what's left over. As Figure I shows, the aftertax price for people who purchase their own health insurance is twice as high for an identical policy.

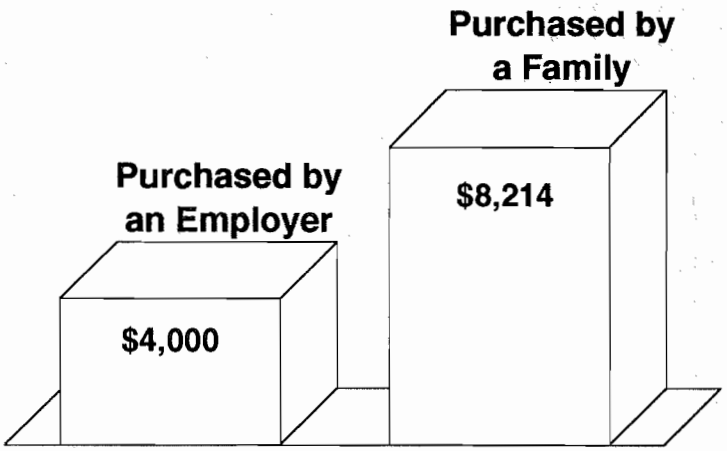
President Bush has proposed a much fairer approach, under which people who purchase their own health insurance would receive a tax credit. The credit would be more substantial, and even transferable, for low-income families.[44]

If tax credits were offered, some people would still choose not to buy health insurance. But in that case, they would pay higher taxes. Under the current system, the higher taxes paid by the uninsured go to Washington, while free health care is delivered by local hospitals. It would be better to pool these extra taxes and make them available to the hospitals that deliver charity care. That way, uninsured patients would be the payers of first resort, but funding would also be available to provide uncompensated care.

"Families who purchase their own health insurance must pay twice as much."

Figure I

Effective Cost of a $4,000 Health Insurance Policy[1]



[1] Figures show the amount of additional pretax income that must be earned in order to purchase the policy. The family is assumed to have adjusted gross income of $35,000 and to face a 28 percent federal income tax rate, a 15.3 percent Social Security (FICA) tax rate, and a combined 8 percent state and local income tax rate.

Source: Gary and Aldona Robbins, Fiscal Associates. For a detailed explanation of the tax differences, see Health Care Solutions for America, "Federal Tax Policy and the Uninsured," Washington, DC, January 1992.

Good Idea: Allowing Employees Choices. The federal tax law and the federal employee benefits law appear to have been designed to make it as difficult as possible for small businesses to offer health insurance to their employees. Reform is needed to make the employer's task easy. Employees should be able to purchase any insurance policy through an employer. The cost of the policy should be included in each employee's gross (taxable) compensation, with a dollar-for-dollar trade-off between health insurance premiums and pretax wages. A tax subsidy should be given directly to each employee and should appear on their personal income tax returns.[45]

This would allow employees the widest range of choices — and would alert them to the full costs of their choices. And since health insurance would substitute for pretax wages, employees would never strike over health insurance benefits. They could have whatever benefits they chose.

Surprisingly, this proposal has generated little enthusiasm among business groups — although it is explicitly designed to take employers off the hook and let employees reap the benefits and bear the costs of their own choices. The reform is supported, however, by a wide array of think tanks and policy groups — including the American Enterprise Institute and the Heritage Foundation.[46]

Bad Idea: Expand Medicaid. As noted above, Medicaid is a rationing program, and evidence of rationing within it is becoming more prevalent. A much better approach is to empower people and make them real participants in the private health insurance marketplace.

"Mandates require workers to produce enough to finance their own health insurance — or go without a job."

Bad Idea: Employer Mandates. Virtually all economists agree that fringe benefits are earned by workers and that they substitute for wages. Requiring employers to provide health insurance, therefore, is simply a disguised attempt to force workers to take health insurance rather than wages. The mandates nominally apply to employers. In reality they force workers to purchase health insurance, whether they want to or not.

There are two types of proposals to mandate employer-provided health insurance. One type simply requires employers to provide insurance.[47] The other gives them a "pay-or-play" option.[48] Both types are far more regressive than proposals to offer refundable tax credits to individuals. The mandates require workers to be able to produce enough to finance their own health insurance or go without a job. [See Exhibit IV.] Tax credits would give more help to those who need it most without interfering with job opportunities.

More importantly, employer mandates are an unstable solution — one which would inevitably lead to national health insurance. If employers are required to purchase health insurance, they will inevitably pressure government to control costs by regulating the price of every medical service. If employers are given a pay-or-play option, they will pressure government to hold down the tax price (the "pay" option), pay the tax and unload their employees onto the government plan. [See Exhibit IV.]

Exhibit IV

What's Wrong With Employer Mandates?

Under a typical pay-or-play proposal, employers would be given a choice: provide health insurance to employees or pay a tax and let government provide the health insurance. Regardless of the specifics, all such plans would have four bad consequences. They would (1) impose a regressive burden on low-income workers, (2) cause a loss of jobs, (3) encourage public rather than private health insurance and (4) inevitably lead to national health insurance.

Regressive Taxes. Pay-or-play plans would have virtually no effect on large companies (which already provide health insurance) or on high-income employees (most of whom are already insured). The plans would have a major impact on small business and low-income employees. The inevitable result is loss of jobs and lower take-home pay.

Loss of Jobs. The Urban Institute estimates that a pay-or-play plan would impose a $36 billion cost on employers and create an additional $30 billion cost for government (probably to be paid by additional taxes on employers and employees). Estimates of the number of people who would lose their jobs range from 710,000 (for a 7 percent pay option) to 965,000 (for a 9 percent pay option).

Why Pay Is More Attractive Than Play. Suppose employers have the option to pay a 7 percent tax or provide health insurance. Considering that about 95 percent of all uninsured workers earn less than $30,000 a year, most of their employers would have strong incentives to pay the tax and forget the problem. William Dennis (NFIB Foundation) has calculated that almost all small business will pay rather than play. According to the Urban Institute, under a 7 percent pay-or-play option, 84.2 million workers and their dependents would fall under the government plan. Overall, *three-fifths of the entire population* would be insured by the federal government.

Opening the Door to National Health Insurance. Pay-or-play plans are inherently unstable. If the tax remains fixed, more employers will unload workers onto the government plan as the cost of health insurance rises. If the tax increases, there will be more unemployment and more unemployed people on the government plan as the cost of health insurance increases. Either way, the number of people covered by the public sector will rise.

Sources: Sheila Zedlewski, Gregory Acs, Laura Wheaton and Colin Winterbottom, "Pay-or-Play Employer Mandates: Effects on Insurance Coverage and Costs," The Urban Institute, January 8, 1992; William J. Dennis, "It's Cheaper to Pay Than to Plan," NFIB Foundation, October 1991; Republican Staff Report, House Committee on Budget, "A Pay-or-Play Cure for U.S. Health Care?", May 11, 1992; and John C. Goodman, "Health Insurance: States Can Help," *Wall Street Journal,* December 7, 1991.

Bad Idea: Individual Mandates. Once a system of tax credits has been instituted, there is no need to mandate anything. People who do not purchase health insurance will pay higher taxes. The higher taxes can be used to pay for uncompensated care for the uninsured, who exhaust their own resources.

"Requiring individuals to purchase health insurance would inevitably lead to government control of the entire health care system."

Nonetheless, both the Heritage Foundation[49] and the American Enterprise Institute[50] have proposed to treat health insurance like auto liability insurance and force individuals to purchase it. The trouble is that mandated health insurance would likely be similar to mandated auto liability insurance in California, Massachusetts and New Jersey. [See Exhibit V.] And like employer mandates, individual mandates would create irresistible pressures for government to keep down the price of health insurance by regulating the entire health care system.

Worst Idea: National Health Insurance. National health insurance would be comparable to enrolling everyone in the Medicaid program. Inevitably it would lead to health care rationing and waiting lines. [See Exhibit III.] In other English-speaking countries with national health insurance, the central question is: How easy is it to get out of the system and take advantage of private sector medicine?

- Although health care is theoretically free to all in England, 10 percent of the population now has private health insurance.[51]
- In New Zealand, one-third of all families have private health insurance and one-fourth of all surgeries are performed in the private sector.[52]
- Although private health insurance has been effectively outlawed in Canada, an increasing number of Canadian patients are crossing the U.S. border to get health care they cannot get in Canada.[53]

State Regulations

State-mandated health insurance benefits laws tell insurers what services and providers they must cover in order to sell health insurance in a state. These laws cover diseases ranging from mental illness to alcoholism and drug abuse, services ranging from acupuncture to in vitro fertilization, providers ranging from chiropractors to naturopaths. They cover everything from the serious to the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and deposits to a sperm bank in Massachusetts.

State mandates are pricing millions of people out of the market for health insurance. By one estimate, one out of every four uninsured people has been priced out of the market by state-mandated benefits laws.[54] In addition to mandates, private insurance is burdened by premium taxes, risk pool assessments and other regulations.

Exhibit V

What's Wrong With Individual Mandates?

In almost every state, people are required to buy auto insurance as a condition for the right to drive. Many — including some who otherwise advocate free market solutions to health care problems — have argued that health insurance should be mandatory, in an analogous way. How well would that work?

Case Study: Automobile Liability Insurance. Massachusetts has the highest automobile insurance premiums in the nation. It also has the highest rate of auto insurance claims. One reason is that Massachusetts subsidizes bad driving through artificially low insurance rates. Under Massachusetts law, insurers are forbidden to base their premiums on age, sex or marital status. Insurers are required to sell policies to almost any driver, and they cannot charge higher premiums for policies transferred to the state's risk pool. As a result, about 94 percent of young male drivers and 82 percent of young female drivers are in the risk pool. As a proportion of all premiums, policies assigned to the risk pool soared from 23 percent of the market in 1977 to 65 percent in 1989.

Whereas nationally only about 8.3 percent of auto insurance premiums represent risk pool insurance, the Massachusetts risk pool now accounts for one-fifth of all the auto risk pool insurance in the United States. The risk pool invariably loses money, and the deficits are financed by higher premiums charged to other drivers. Overall, there is little relationship between driving behavior and insurance premiums in Massachusetts.

Similar problems are occurring in California and New Jersey.

Proposals to Treat Health Insurance Like Auto Liability Insurance. If individual health insurance were mandatory, health insurance prices — like auto liability insurance prices — would be determined in the political arena. Moreover, because health insurance is a far more emotional issue than auto liability insurance, the experience of Massachusetts and other states is only a small indication of the political crisis that would be created.

Opening the Door to National Health Insurance. Realistically, the federal government cannot require the purchase of health insurance and leave insurers, providers and state legislators free to increase the price without limit. Mandating health insurance is an open invitation to federal regulation of the entire health care system.

Sources: Simon Rottenberg, *The Cost of Regulated Pricing: A Critical Analysis of Auto Insurance Premium Rate-Setting in Massachusetts* (Boston: Pioneer Institute, 1989); and John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute), forthcoming.

Ironically, most large corporations are exempt from these regulations because they self-insure.[55] As a result, the full weight of these regulations falls on the most defenseless part of the market: the self-employed, the unemployed and the employees of small businesses.

Good Idea: Exempt Everyone. The most straightforward way to lift the burden of state mandates is to enact a federal override, effectively abolishing them. Failing that, insurers should be allowed to sell a federally qualified, no-frills policy in every state. Mandate-free insurance could compete side-by-side with regulated insurance. This would extend to the rest of the population a right now enjoyed only by employees of the largest corporations.

Mediocre Idea: Exempt Small Businesses. At one time it was thought that significant progress could be made in exempting small businesses from mandated benefits. Indeed, over the past few years, 24 states have done so to one degree or another.[56] Unfortunately, most of these laws are so narrowly constructed that the qualifying firms are few and dispersed. Unable to identify a large enough market, most insurers have simply ignored it.[57]

Bad Idea: Do Nothing. The desire to override state regulations (or create an escape from them) cuts across ideological lines. Repeal of state mandates, for example, was part of Senator Kennedy's proposal for employer-mandated health insurance and is included in the more recent Senate Democrats' pay-or-play proposal.[58]

"Federal law exempts the powerful and leaves the weak to fend for themselves."

The conservative Heritage Foundation is of a different view. While denying that individuals have rights *not* to purchase health insurance, Heritage asserts that state governments have the right to regulate in any way they wish. Heritage would use the federal government to force people to buy insurance, but under the theory of states' rights would leave state governments free to boost the cost of insurance without limit.

Worse Idea: Repeal the Exemption for Large Companies. There is something intrinsically wrong with a reform proposal if its proponents argue that in order to reform the system for some people, other people must also be included. Yet that's what many state reformers are arguing. They see the exemption for self-insured companies as a major impediment and argue that it should be repealed. Their argument is baseless and should be rejected.

Very Worst Idea: Encourage Federally Mandated Health Insurance Benefits. Since health insurance is regulated at the state level, all the pressure for mandated benefits laws has been on state legislators — so far. However, a number of health care reform proposals require the federal government to specify a package of benefits. Once this occurs, special-interest lobbyists will quickly make their way to Washington to press for their clients' inclusion in the package.

This has already happened in one notorious case. Even though Sen. Edward Kennedy's (D-MA) proposal to require employers to provide health insurance was designed to override state mandates, and even though Kennedy wanted to keep the cost low, he quickly gave in to pressure to expand the benefits in the basic package. Whereas most estimates place the cost of insuring the uninsured at $30 billion to $40 billion per year, Kennedy's basic package became even more generous than that offered by major employers. As a result, the cost of bringing existing employer-provided coverage up to Kennedy-bill levels would have been an additional $68 billion a year.[59]

"Special interests tripled the cost of the Kennedy bill."

In general, any health care reform proposal that requires the federal government to specify a package of health insurance benefits is an open invitation to special interests to switch their lobbying force to the nation's capital.[60] This includes plans to force individuals to purchase health insurance as well as employer mandates.[61]

Paying for Reform

Even the best reform proposals would cause a loss of revenue for the federal government. How should they be paid for?

Good Idea: Redirect Current Spending. Many people have the impression that most federal health care spending pays medical bills or buys health insurance for people who could not otherwise afford it. In fact, an enormous amount of federal money benefits high-income earners. For example, each year the federal government "spends" about $60 billion in tax subsidies for employer-provided insurance.[62] Yet as Figure II shows, families in the top fifth of the income distribution get about six times as much benefit from these subsidies as families in the bottom fifth. One way to pay for health care reform is to eliminate, or at least sharply reduce, subsidies to people who can afford their own health care insurance.

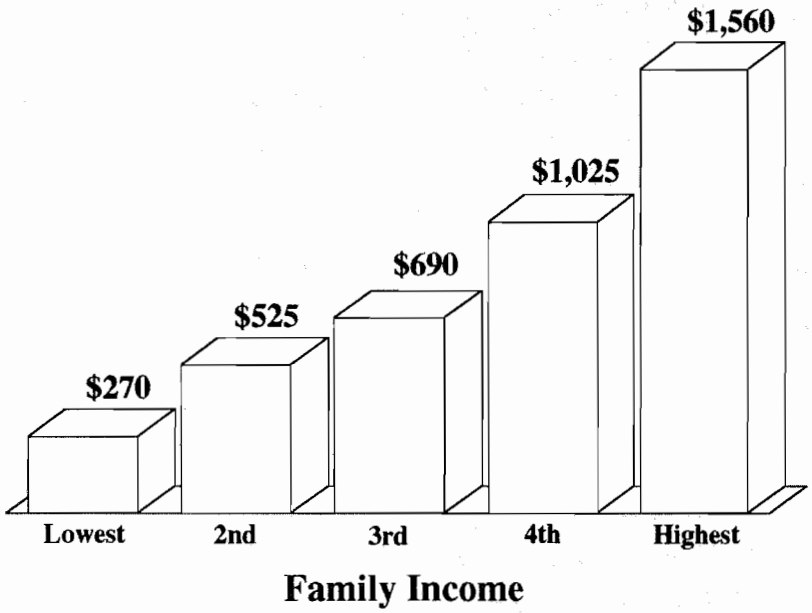
The Medicare program also spends an enormous amount on people who least need help. In 1992, the federal government will spend more than $135 billion on Medicare — most of it on the elderly. Yet the elderly have more aftertax income and considerably greater wealth than the nonelderly. In fact, by one estimate, the elderly own 40 percent of the capital in the country.[63] One way to pay for health care reform is to require the high-income elderly to pay a larger portion of their health care bills.

Bad Idea: Tax Sick People. A number of proposals, including one recently passed in Minnesota, pay for health care reform by taxing hospital beds or hospital revenues. This idea is a continuation of a long-established hospital practice of financing charity care by overcharging paying patients.

"High-income families get six times as much benefit as low-income families."

Figure II

Average Benefit for a Family From Tax Subsidies for Health Insurance[1]



[1]Subsidies include reduced Social Security (FICA) and income taxes.

Source: C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference on American Health Policy, Washington, October 3-4, 1991.

In general, if there is a social reason for government intervention, the cost should be borne by society as a whole. The worst possible way to pay for any social program is to tax sick people — which takes funds from people at a time in their lives when they can least afford it.

Bad Idea: Tax Health Insurance. Another common proposal is to fund health care reform by taxing health insurance. For example, most health insurance risk pools are funded by a tax on health insurance premiums. And many health insurance reform proposals are designed to lower premiums for high-risk (or sick) people by raising the price for low-risk (or healthy) people.

If it is socially desirable for people to have health insurance, then any policy that artificially raises premiums is inconsistent with achieving that goal. Charging healthy people higher premiums simply discourages more people from being insured.

Worst Idea: Tax Rich People. A popular way of funding any government program is to levy higher taxes on high-income earners. Unfortunately, most of these proposals would tax investment income, harming workers and the economy far more than the people who are taxed. In general:[64]

- People who earn more than $250,000 per year derive 65 percent of their income from investments.
- People who earn more than $1 million a year derive 75 percent of their income from investments.

"Taxes on investment income hurt workers far more than they hurt investors."

Taxes on high-income earners, therefore, are almost always taxes on investment income. Higher taxes on investment income invariably reduce investment, lower wages and eliminate jobs. Usually, such taxes also cause a net loss of revenue rather than a gain. Under the current tax structure:[65]

- For every dollar of aftertax income to investors, workers receive $12 in aftertax wages and government receives another $12 in tax revenue.
- Thus, every extra dollar taken from investors ultimately means $12 less in revenue for government.

Conclusion

The array of ideas for health care reform ranges from the good to the bad to the ugly. The best ideas are:

1. To reform the market for private insurance, require health insurance to be guaranteed renewable, personal and portable, and encourage a competitive market in which risk is priced accurately.
2. To encourage cost control, allow individuals to have tax-favored Medical Savings Accounts.
3. To insure the uninsured, give refundable tax credits to people who purchase their own health insurance.
4. To pay for indigent health care, recycle the higher taxes paid by uninsured people to hospitals that provide charity care.
5. To prevent state governments from pricing more people out of the market for health insurance, either override state mandates or allow insurers to sell no-frills policies.

"Reforms that work draw on the strengths of the private sector to solve problems."

6. To pay for health care reform, redirect current federal spending from higher to lower income families.

These reforms would draw on the strengths of the private sector to solve problems — by creating institutions under which people would find it in their self-interest to achieve desirable social goals.

John C. Goodman

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Footnotes

[1] See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington DC: Cato Institute), forthcoming.

[2] To the degree that employees pay part of the premium, the price tends to be the same for all employees — regardless of expected health care costs.

[3] Polls show that about 30 percent of employees experience "job lock" — a condition under which they fear switching jobs because of a loss of health insurance benefits. Eric Echolm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.

[4] Risk pools, which have been established by more than 26 states, guarantee availability of health insurance to all individuals, regardless of health status. Premiums are usually 150 percent to 200 percent higher than for comparable policies sold in the market. Even with higher premiums, however, most risk pools incur losses. See *Comprehensive Health Insurance for High-Risk Individuals*, 5th ed. (Minneapolis: Communicating for Agriculture, 1991).

[5] John C. Goodman, "Should Healthy People Pay More For Health Insurance?," National Center for Policy Analysis, NCPA Policy Backgrounder No. 115, April 1992.

[6] Insurers would be worse off because the reform would further erode a real market for insurance. Small businesses would be worse off because they would be forced to pay higher premiums. Physicians would be worse off because the number of uninsured people would rise. All three groups would suffer even more in the long run because political pressures would soon convert guaranteed-issue insurance into community rating with no waiting period, which would effectively destroy the market for private health insurance.

[7] Employee Benefits Research Institute (EBRI) Issue Brief, No. 110, January 1991.

[8] Jill D. Foley, *Uninsured in the United States: The Nonelderly Population Without Health Insurance* (Washington, DC: Employee Benefits Research Institute, April 1991), p.16.

[9] "President's Comprehensive Health Reform Program," February 6, 1992. During an initial transition period, premium "bands" would allow some variation in premiums for individuals of the same age and sex. Ultimately, however, through a reinsurance mechanism, "insurers would be able to provide coverage at a near uniform premium for the sick and the healthy," p. 23.

[10] "In cases where a hospital emergency room is an individual's first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So for example, a homeless person entering the hospital and having no preference for any carrier would be assigned to an insurer by rotation and the credit would automatically flow to the insurer." "President's Comprehensive Health Reform Program," p. 22. Technically, a "credit-eligible" person is defined as a person whose annual income does not exceed $50,000 for an individual or $80,000 for a family. However, since the hospital will almost certainly not know the emergency-room patient's income until several days after treatment, and since there is no waiting period, the proposal apparently envisions a mechanism that will insure any uninsured patient entering the hospital.

[11] Health Care Financing Administration, Office of the Actuary.

[12] For an extensive analysis of the concept, see John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

[13] Source: Golden Rule Insurance Company. Figures are for two adults and two children in a city with average health care costs. For deductibles less than $2,500, policyholders face a 20 percent copayment up to $1,000. Thus the foregone coverage is 80 percent x ($1,000 - $250) = $600. The savings from a higher deductible are even greater, considering that more than one family member can incur expenses. Under the low-deductible policy, the deductible is $250 per person, with a $500 maximum for the entire family. Under the high-deductible policies, the deductible indicated is for the entire family.

[14] The foregone coverage is 80 percent x ($2,500 - $250) = $1,800.

[15] See Goodman and Musgrave, "Controlling Health Care Costs with Medical Savings Accounts."

[16] See Task Force Report, "An Agenda for Solving America's Health Care Crisis," National Center for Policy Analysis, NCPA Policy Report No. 151, May 1990.

[17] U. S. Department of Treasury, *Blueprint for Tax Reform* (Washington DC: DOT, 1977).

[18] At the time this report was issued, marginal tax rates were much higher and taxpayers could deduct medical expenses in excess of 3 percent of income (compared to 7 percent today). Under current conditions, the proposal might fund catastrophic coverage in excess of 15 percent of income.

[19] Friedman would require every U.S. family to own a high-deductible major medical policy. Although he prefers private insurance, he argues that government catastrophic insurance would be an improvement over the existing system. See Milton Friedman, "Gammon's Law Points to Health-Care Solution," *Wall Street Journal*, November 12, 1991.

[20] Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington: The Heritage Foundation, 1989).

[21] The extra income is allocated equally to each year in order to maintain the same pattern of consumption of other goods.

[22] For health insurance, the annual premium would be $50. For self-insurance, the individual must allocate $72 each year, of which $36 is consumed in taxes and $36 saved for the first three years.

[23] Under the Heritage proposal, there would be a natural pressure from the medical community to allow providers to bill government directly for the government's share of the medical bills — inviting government regulation of price. This would be especially true for low-income patients, for whom Heritage imagines that government would pay most of the bill anyway. [See the following footnote.]

[24] This list of problems is by no means exhaustive. The peculiarities of the Heritage plan also give rise to other problems. For example, Heritage recommends refundable tax credits for the purchase of health insurance by low-income families. But to be consistent, it argues for refundable tax credits for out-of-pocket spending as well. Perversely, the subsidy rates can become so high that third-party insurance encourages more prudent buying of medical care than direct out-of-pocket purchases. [See note 1 to Exhibit II.] In addition, Heritage recommends larger tax credits for larger medical expenses. Thus the tax credits would range from 20 percent for small medical bills to 75 percent for expenses in excess of 10 percent of family income. This tax structure perversely encourages people to overinsure for small medical bills and skimp on catastrophic coverage. See Butler and Haislmaier, *A National Health System for America,* p. 59.

[25] Medicare pays hospitals a predetermined reimbursement fee for 492 diagnosis-related groups. Medicare's DRG system for reimbursing hospitals is a price fixing scheme in which the government is attempting to create an artificial market. DRG reimbursement prices do much more than limit the amount that government will pay. Since Medicare patients cannot add their own funds to the DRG rate and hospitals cannot give rebates to patients, Medicare literally fixes the prices of services rendered, independent of conditions of supply and demand.

[26] The Health Care Financing Administration (HCFA) began on January 1, 1992 to phase in the Resource Based Relative Value Scale (RBRVS), a cost control and payment program which will reimburse physicians who care for Medicare patients.

[27] Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine*, Vol. 321, No. 21, November 16, 1989, pp. 1378-83.

[28] Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 909-10. See also Phillip J. Held, et al., "Mortality and Duration of Hemodialysis Treatment," *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 871-75.

[29] Kane and Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," p. 1379.

[30] Eric Muñoz, et al., "Race, DRGs and the Consumption of Hospital Resources," *Health Affairs,* Spring 1989, p.187.

[31] Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs*, Fall 1991, p. 43.

[32] See *Choices for Health Care: Report of the Health Benefits Review* (Wellington, New Zealand: Health Benefits Review Committee, 1986), pp. 78-79; and John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

[33] Estimate of the Fraser Institute (Vancouver) based on sampling in five Canadian provinces.

[34] It is estimated that in the United States about 4 percent of the population accounts for about 50 percent of total health care costs. These are the patients who require surgery and access to expensive technology.

[35] For New Zealand, estimate of the New Zealand Department of Health. OECD statistics show an occupancy rate of 74.8 percent for New Zealand in 1983 and 83.3 percent for Canada. See Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris: OECD, 1987), Table 29, p. 67. The most recent OECD statistics are expected to show an occupancy rate of 80.3 percent for acute care hospitals and 82.7 percent for all hospitals in Canada for 1987. See George J. Schieber et al., "Health Care Systems in Twenty-four Countries," Exhibits 4 and 5, pp. 27, 29. In England, hospital occupancy rates are 74 percent for acute beds and 82 percent for all beds. See Office of Health Economics, *Compendium of Health Statistics*, 7th ed. (London: OHE, 1989), Section 3, p. 39.

[36] See Joseph A. Califano, *America's Health Care Revolution: Who Lives, Who Dies, Who Pays?* (New York: Random House, 1986).

[37] Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?", *Journal of the American Medical Association*, Vol. 262, No. 21, December 1, 1989, p. 3028.

[38] For example, a national market is developing for expensive heart surgery, in which "centers of excellence" bid for the opportunity to perform for corporate, insurance and government buyers.

[39] Brook, "Practice Guidelines and Practicing Medicine," p. 3029.

[40] Jane Orient, "An Evaluation of Abdominal Pain: Clinicians' Performance Compared with Three Protocols," *Southern Medical Journal*, Vol. 79, No. 7, July, 1986, pp. 733-39.

[41] Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey," *EBRI Issue Brief*, No. 123, February 1992.

[42] Katherine Swartz and Timothy D. McBride, "Spells Without Health Insurance: Distribution and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry*, Vol. 27, Fall 1990, pp. 281-88.

[43] Employee Benefit Research Institute, *EBRI Issue Brief*, No. 110, January 1991.

[44] "The President's Comprehensive Health Reform Program," p. 29. Low-income individuals would receive a transferable credit certificate rather than a tax deduction. The credit would be transferred to an employer or to an insurer who would provide health insurance in payment for coverage.

[45] The amount of the tax subsidy should vary with income in the manner described above.

[46] See Task Force Report, "An Agenda for Solving America's Health Care Crisis"; and Butler and Haislmaier, *A National Health System for America*.

[47] Senator Edward Kennedy (D-MA), for example, has proposed such legislation. For an analysis see John C. Goodman, Aldona Robbins and Gary Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1989.

[48] Under this type of proposal, unveiled in 1991 by Senators Mitchell (D-ME), Kennedy (D-MA), Rockefeller (D-WV) and Riegle (D-MI), employers would have a choice: Pay a federal tax, tentatively set at about 7 percent of payroll, or provide health insurance for their employees. If employers opted to pay the tax, the government would assume responsibility for providing health insurance.

[49] The first element of the Heritage Foundation's plan states, "Every resident of the U.S. must, by law, be enrolled in an adequate health care plan to cover major health care costs" [p. 51].

[50] See Mark Pauly, et al., "A Plan for 'Responsible National Health Affairs'," *Health Affairs*, Spring 1991, pp. 5-25.

[51] Day and Klein, "Britain's Health Care Experiment," pp. 43-44.

[52] *Choices for Health Care*, p. 75.

[53] Goodman and Musgrave, "Twenty Myths About National Health Insurance."

[54] John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

[55] Under the provisions of the Employee Retirement Income Security Act, 1974.

[56] Greg Scandlen, cited in "States Reconsider Health Plan Mandates," *Medical Benefits*, Vol. 7, No. 21, November 15, 1990, p. 9.

[57] For instance, 14 states require that a "small business" have no more than 25 employees. Many states allow a small business to qualify only if it has been without insurance for some period of time, say, one to three years. See John C. Goodman, "Health Insurance: States Can Help," *Wall Street Journal,* December 17, 1991.

[58] Though the Kennedy plan would repeal state mandates, it would institute national mandates such as mental health benefits. About two-thirds of the cost of the bill would go to expand coverage for currently insured workers. See Goodman, Robbins and Robbins, "Mandating Health Insurance."

[59] Ibid.

[60] The exception to this generalization is the proposal (made above) to allow insurers to sell a no-frills policy in all states. Special interests, of course, would try to put special mandates in the no-frills package. But the worst that could happen is that the no-frills package would expand to include more mandates than states require. In that case, people would be free to purchase state-regulated insurance.

[61] Just as Senator Kennedy constructed a specific package of benefits, the Heritage Foundation has done so as well. See Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage Consumer Choice Health Plan," Heritage Talking Points, Washington, DC, Heritage Foundation, March 5, 1992, Table 2, p. 10.

[62] Since employers purchase health insurance with pretax dollars, employees receive a subsidy that can be worth up to half of each dollar spent on health insurance.

[63] Aldona Robbins and Gary Robbins, "Taxing the Savings of Elderly Americans," National Center for Policy Analysis, NCPA Policy Report No. 141, September, 1989.

[64] Aldona Robbins and Gary Robbins," Capital, Taxes and Growth," National Center for Policy Analysis, NCPA Policy Report No. 169, January 1992.

[65] Ibid.