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HEALTH POLICY ISSUE:

A Layperson's Guide to Health Insurance Reform

"Many 'reform' proposals would only make the problems worse."

Serious problems exist in the market for private health insurance. Among them: (1) many people discover 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 lose coverage find that no other insurer will insure them.[1]

At both the state and federal levels, a number of proposals purporting to solve these problems would in fact make them worse. Some of the proposals would also exacerbate other problems — causing more people to be uninsured and contributing to rising health care costs.

In theory, the problems in the market for private health insurance are not difficult to solve. [See the sidebar on solving the crisis in private health insurance.] In practice, they have so far proved impossible. The reason is the lack of consensus over the social role of health insurance.

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Solving the Crisis in Private Health Insurance

Real problems exist in the private health insurance industry. These problems have arisen because the traditional insurance philosophy has been abandoned. All too often what is called insurance is actually prepayment for the consumption of medical care. To solve the problems, legislation is probably needed. But a workable solution must be one that encourages a competitive market for real insurance — one in which risk is accurately priced.

Problem: People Who Cannot Afford to Insure. Most uninsured Americans are healthy, not sick. They lack health insurance because they have been priced out of the market. Part of the answer is to encourage insurers to charge these people low premiums that reflect their low level of risk. State governments can help by repealing cost-increasing regulations and the federal government can help by giving tax subsidies for the purchase of health insurance to low- and moderate-income families.

Problem: People Who Can Afford to Insure but Choose Not to. If tax incentives were created, some people still would 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, and funds would be available to pay for uncompensated care.

Problem: People Who Are Uninsurable. Less than 1 percent of the nonelderly population cannot buy health insurance because they are sick or at high risk. Government can help them by creating risk pools or by subsidizing their medical expenses. The amount of subsidy should depend on family income. Low-income families need government help. Ross Perot does not.

Problem: Unfair Cancellations and Premium Increases. Sensible reform is needed for people who already have insurance. Insurers should not be able to change the rules of the game after an unexpected illness has occurred by canceling a policy or unreasonably increasing premiums. Terminally ill people who have life insurance can continue their coverage at pre-agreed premiums. There is no reason why health insurers can't follow a similar practice.

Problem: Job Lock. Thirty percent of employees say they, or others in their household, have stayed on a job they wanted to leave because they did not want to lose employer-provided insurance coverage. Even though economists are almost unanimous in the belief that health insurance costs are fully paid for by workers (as a fringe benefit that substitutes for wages), our outmoded employee benefits system treats the policy as belonging to the employer. This might be acceptable if employees worked for the same employer for the whole of their work life. In fact, most do not. A reasonable solution is to insist that health insurance benefits be personal and portable.

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

Two Visions of Health Insurance

Behind the debate over health insurance reform are two competing visions of the social role of health insurance.[2] On one side are those who see the need for — and the value of — a healthy market for real insurance. On the other are those who would like to abolish health insurance and replace it with something else.

"In a competitive insurance market, there is a natural tendency to price risk accurately."

Health Insurance as Real Insurance. The purpose of real insurance is to protect a person's assets against the cost of a risky event. Individuals must decide to what extent they wish to self-insure and bear the risk personally rather than to buy insurance and transfer the risk to someone else. They are able to make good decisions only to the extent that risk is priced accurately. If insurance is underpriced, they will overinsure. If it is overpriced, they will underinsure.

Health Insurance as Prepayment for the Consumption of Medical Care. For most of the post-World War II period, the health insurance market has been dominated by the view that health insurance exists to pay for the consumption decisions of policyholders. Viewed in this way, health insurance is not real insurance; it is prepayment for the consumption of medical care.

This explains why health insurance so often pays expenses that have nothing to do with a risky event (e.g., checkups, diagnostic tests, etc.) In general, each policyholder is free to spend other people's money in a market that is continually creating new options for buyers. However, if people consume more (e.g., see doctors more often), premiums must be raised to cover the increased costs. Indeed, *the primary reason health care costs and health insurance premiums are soaring in the United States is that, to a large extent, health insurance has become prepayment for the consumption decisions of policyholders.*[3]

Until recently, the advocates of using health insurance as prepayment for the consumption of medical care favored complete autonomy for physicians and hospital personnel. The role of insurers was to pay whatever bills the providers submitted. Today, most of these people are strong proponents of *managed care*. In fact, many reform proposals would force health insurers to stop selling insurance and start selling managed care services instead.

How Should Health Insurance Be Priced to New Buyers?

The two different visions of the social role of health insurance have led to two different answers to this question.

Competitive Markets. If the health insurance marketplace is competitive, there will be a natural tendency to price risk accurately. Different people will pay different premiums, depending upon the likelihood that they will incur claims. Policies sold to individuals will be combined with other policies in a larger market. The price charged to a specific buyer will reflect the expected cost and risk that individual adds to the large pool.

Currently, the cost of insuring a 60-year-old male is about three to four times that for a 25-year-old male. The likely cost of insuring someone living in Los Angeles is about three to four times that of someone living in Vermont. In competitive markets, premiums would reflect these expected costs. Buyers would pay for what they get.

Pure Community Rating. At the other end of the spectrum is community rating. Under this pricing system, once practiced by many Blue Cross/ Blue Shield plans, everyone is charged the same premium — regardless of age, type of work, medical history or any other indicator of health risk. Since the price charged must reflect the average cost, combining the sick with the healthy, under community rating high-risk applicants are undercharged and low-risk applicants are overcharged.

"Under community rating, there is no relationship between individual premiums and health insurance risks."

Community rating cannot work in a normal marketplace. It can be sustained only by the force of law or in markets where there is a single, monopoly insurer. In the days when Blue Cross practiced community rating, it had a monopolistic position. When commercial insurers entered the market, they succeeded by charging healthier people lower premiums. Blue Cross had to either abandon its pricing policies or be left with only sick policyholders. Today, community rating exists only where it is mandated by law and within the confines of large companies.[4]

Mixed Systems. Most of the misguided reform proposals discussed below do not embrace pure community rating. They do try to push the market in that direction, however. Virtually all of the proposals would force insurers to charge higher prices to healthy people. The focus of these proposals is on paying the bills of people who are already sick, not on making real insurance available at actuarially fair prices to healthy people.

How Should Health Insurance Be Priced to Current Policyholders?

Some of the most troublesome problems in the health insurance industry relate to the experience of policyholders who become sick. To appreciate why these problems arise, it is helpful to compare health insurance with life insurance.

"There would be fewer problems if health insurance functioned like life insurance."

Life Insurance Successes. Most life insurance contracts are guaranteed renewable — the insurer cannot cancel the policy after the insured contracts a life-threatening illness. Even terminally ill people have the right to continue paying premiums, often at guaranteed rates. In addition, there are usually limits on how much the premiums can rise in future years, and the insurers cannot increase the premium for one policyholder without increasing it by the same amount for everyone else who holds the same type of policy.

Health Insurance Failures. Not long ago, the health insurance marketplace functioned in a similar way. Guaranteed renewable policies were common. Insurers could not cancel coverage simply because a policyholder became sick, and a premium increase for one had to be matched by increases for all others. There is some evidence that state regulation is responsible for the virtual disappearance of guaranteed renewable individual and family policies. Even bigger problems have arisen in the market for small group coverage, for a different reason.

The Source of Failure: Insurance as Prepayment for the Consumption of Health Care. For all practical purposes, large companies have not been able to purchase real health insurance for years. Under a common arrangement, this year's premiums equal last year's health care costs. What the employer pays in premiums must equal whatever the employees consume in the medical marketplace.

When insurers try to force this philosophy on small businesses, however, havoc results. Many small employers are shocked to learn that after an employee incurs an expensive-to-treat illness, the insurer can cancel the policy or raise the rates without limit. Thus insurers can change the rules of the game unilaterally, *after* the risky event has occurred. The insurers argue that, as in the case of a large company, an employer's premiums must be increased to pay the employees' medical expenses. The employer reasonably asks, "If our premiums have to equal our medical costs, what's the purpose of buying insurance?"

The Best and Worst Ideas for Health Insurance Reform

Politicians confronting the difficult issue of health insurance face a dizzying array of plans for reform. In fact, there are so many plans that most policy analysts have ceased trying to keep track of them. Yet the vast majority of plans — both good and bad — are based on a few simple ideas. The following is a brief summary.

"Insurers should not be able to change the rules of the game after an illness has occurred."

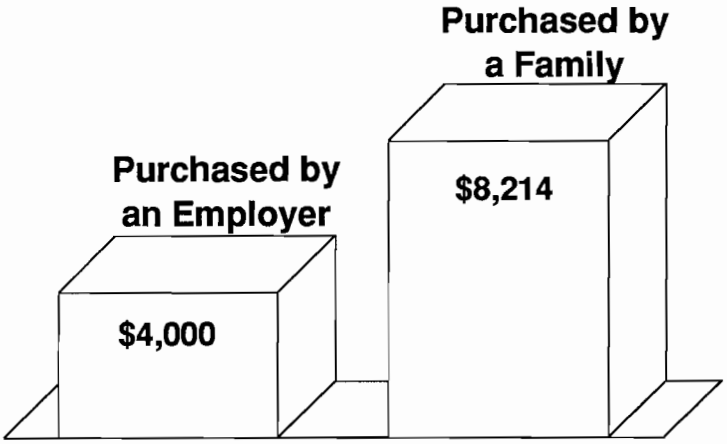
Good Idea: Guaranteed Renewability. Most of the problems in the market for private health insurance do not exist in the market for life insurance, which can easily be taken as a model. Once a person becomes insured, health insurers should be required to continue to offer coverage in the future at reasonable prices.[5] With this reform, the market for small group insurance would begin to resemble the market for individual policies. In the latter market, insurers cannot selectively raise prices for different policyholders based on last year's experience. The same premium increase must apply to the entire class of people who purchase a particular type of policy. Thus insurers cannot change the rules of the game for a single policyholder *after* an illness has occurred.

Good Idea: Personal Benefits. The federal tax law and the federal employee benefits law make it very difficult for small businesses to offer health insurance to their employees. Reform is needed to make the employer's task easier. 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 (a deduction or a tax credit) should be given directly to each employee and should appear on their personal income tax returns.[6]

Good Idea: Portable Benefits. The U.S. health care system has been shaped and molded by the tax law. The kind of health insurance most of us have is determined by what the tax law subsidizes. This has led to an employer-based system under which people lose their health insurance when they leave a firm.[7] Almost all economists believe that fringe benefits are a substitute for wages. Thus fringe benefits are "paid for" by workers in the form of lower take-home pay. Yet despite the fact that employees pay for their own health insurance, they have no ownership rights. Employers can cut back on coverage, even after an employee gets sick.[8] And when employees with a preexisting illness leave, they may find it impossible to get insurance

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 an 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 an 8 percent combined state and local income tax rate.

Source: Aldona and Gary Robbins, Fiscal Associates.

"People who purchase their own health insurance pay twice as much because of federal tax law."

elsewhere. A much fairer system would be one under which no tax subsidy is made available for employer-provided health insurance unless the policy is personal and portable.

Good Idea: Tax Fairness. This year the federal government will "spend" about $60 billion in tax subsidies for health insurance. 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. Thus government is effectively paying half of the premium for people who can "purchase" health insurance through an employer, while people who purchase their own health insurance must pay taxes first and buy 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.

"To encourage people to become insured, government should give the greatest tax relief to families with the lowest incomes."

Ostensibly, this subsidy is meant to encourage private health insurance coverage. Actually, it probably does more harm than good for three reasons. First, the largest subsidies go to the people who need them least — people who probably would purchase health insurance without any tax encourage-

ment. [See Figure II.] Second, the tax law penalizes people who purchase their own health insurance — encouraging them to postpone becoming insured until they can do so through an employer. Finally, the tax law encourages a system under which people who are insured through an employer can lose their coverage — and become uninsurable — after they get sick.

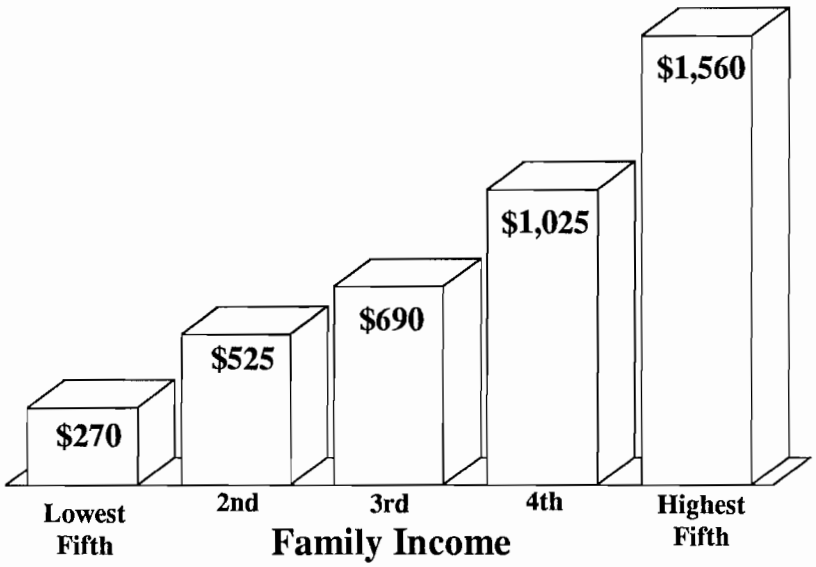
A much fairer approach would be to give people who purchase their own health insurance a tax credit. The credit would be more substantial, and even refundable, for low-income families.[9]

Good Idea: Medical Savings Accounts.[10] Health care spending in the United States is 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]

"High-income families get more than six times as much help from the federal government as low-income families."

FIGURE II

Average Benefit for a Family From Tax Subsidies for Health Insurance



*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, American Health Policy, Washington, DC, October 3-4, 1991.

- 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.

That Americans are overinsured is no accident. As already mentioned, federal tax law effectively subsidizes half the cost of health insurance for many workers. Yet 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 could save a great deal of money by simply choosing high-deductible health insurance:[12]

- 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 forgo, 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). [See the sidebar.] 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.

"With the widespread use of Medical Savings Accounts, we could reduce the nation's health care spending by one-fourth."

Bad Idea: Guaranteed Issue. 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.

Federal Policy Needed to Control Health Care Costs: Medical Savings Accounts

No one is better suited to making decisions about the trade-offs between money and health care expenditures than informed patients, acting on the advice of their physicians. People differ greatly in their attitudes toward risk and in the value they place on health versus other uses of money.

One way to give patients greater control over their health care dollars is to allow individuals or their employers to make tax-free deposits each year to Medical Savings Accounts (MSAs). The accounts would be similar to Individual Retirement Accounts (IRAs), but would be used to fund health care expenditures over a person's lifetime.

People would pay small medical bills with funds from the accounts. They could buy high-deductible health insurance policies for protection against catastrophic expenses. Money for deposits to the accounts could come from the premium savings associated with higher deductibles. In a city with average health care costs, a family can save about $1,315 annually by choosing a policy with a $1,000 deductible rather than a $250 deductible. The savings would be less for group policies, but still substantial.

MSAs would be allowed to grow tax-free, with withdrawals permitted only for legitimate medical expenses. They would be the private property of the account holder and become part of an individual's estate at the time of death. If created by an employer, they would be personal and portable for the employee. Eventually, the funds could pay for postretirement health care or be rolled over into an individual's IRA or pension fund.

The biggest obstacle is the U. S. tax code, which subsidizes health insurance premiums paid by an employer but taxes dollars destined for medical savings. Under current tax policy, if an employer buys a high-deductible policy and tries to pass the savings on in the form of higher wages, or to place the money directly into a savings account, up to half of the amount goes to taxes. Current law encourages low-deductible health insurance, with insurers paying small medical bills that would be much less expensive if paid out-of-pocket.

If everybody had catastrophic health insurance for large medical bills and MSAs for small bills, the administrative costs of the U. S. health care system would be reduced an estimated $33 billion. More prudent buying of health care by patients could reduce spending by another $207 billion.

Medical Savings Accounts could also solve Medicare and Medicaid problems. People on Medicaid might have a government-provided account to draw on. The elderly could choose higher Medicare deductibles and make deposits to their own MSAs.

If most medical expenses were paid by people using their own MSA funds, patients would have a financial self-interest in eliminating waste and reducing costs in the medical marketplace and greater control over how their health care dollars were spent. Third-party payers would interfere far less in the doctor-patient relationship. And health insurance companies could specialize in what they do best: managing risks for rare, expensive, catastrophic medical events.

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.

What's Wrong with Charging Healthy People More for Health Insurance?

When people who do not have health insurance become sick and generate large medical bills, they frequently cannot pay those bills from their own resources. Yet because we generally require hospitals to provide health care to people regardless of ability to pay, a social problem is created. Who should pay the costs of uncompensated care?

The obvious answer is to pay for it with public funds, placing the ultimate burden on taxpayers. But rather than raise taxes to pay for what clearly is a social problem, many politicians want to raise the health insurance premiums of healthy people instead. These proposals require insurers to charge the same price to all buyers — whether healthy or sick. The healthy would be overcharged so that the sick could be charged a premium much lower than their expected health care costs.

Imposing a Regressive, Hidden Tax. By forcing insurance companies to pay the medical bills of people who are already sick, politicians would be indirectly shifting the cost (through premium increases) to healthy people who buy health insurance. In so doing, they would be imposing a hidden, highly regressive tax on unsuspecting families. Whereas the income tax system is designed so that higher income families pay higher tax rates, many health insurance reform proposals would impose the highest hidden tax rates on the lowest income families. For example, if health insurance reform causes the premiums for family policies to rise by $1,000, that's a 10 percent tax on a family with a $10,000 annual income but only a 1 percent tax on a family with $100,000 in income. Thus the tax rate on a family with the lower annual income would be ten times as high.

Increasing the Number of People without Health Insurance. Contrary to widespread impressions, most of the 33 to 34 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age, in the healthiest population age groups. They have below-average incomes and few assets and tend to be very sensitive to premium prices.

Moreover, the primary reason why most of the uninsured lack health coverage 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.

Subsidies vs. Price Controls. Price control solutions cause great harm in order to do a little good. A much better approach would be to directly tackle the problems of the less than 1 percent of the population that is uninsurable — and allow the other 99 percent to buy real health insurance.

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

"Why buy health insurance while you are healthy if you can buy it for the same price after you get sick?"

A number of reform proposals, however, would force insurers to sell policies at fixed prices — no matter how sick or well the applicants are. Under these proposals, insurers would be forced to overcharge low-risk (healthier) people in order to undercharge high-risk people.[15] Whereas guaranteed renewability would encourage people to purchase health insurance (because they would be confident that, once sick, they could continue coverage at reasonable rates), guaranteed issue would have the opposite effect. Why buy health insurance today if you know you can buy it after you get sick?

According to one estimate, no more than seven-tenths of 1 percent of Americans under the age of 65 are uninsurable.[16] Yet in an attempt to make health insurance more affordable for this tiny number, 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. [See the sidebar on charging healthy people higher premiums.]

Virtually all studies of guaranteed-issue insurance have concluded that it increases costs.[17] For example, a recent study for the Society of Actuaries compared medically underwritten policies with guaranteed-issue insurance, under which all preexisting illness limitations were waived after 12 months.[18] The study showed that:

- The cost of guaranteed-issue insurance was 23 percent higher the first year and 50 percent higher the second year.[19]
- The seven-year cost of guaranteed-issue insurance was 39 percent higher.[20]
- These numbers imply that if people who are now medically underwritten could buy only guaranteed-issue insurance, from one-fifth to one-half of them would choose to be uninsured.[21]

Worst Idea: Community Rating. The concept of guaranteed issue is often combined with the concept of community rating. As noted above, under "pure" community rating — such as the plan about to be adopted in New York[22] — insurers are forced to charge the same price to every policyholder, regardless of age, sex or any other indicator of health risk. Under "modified" community rating, price differences are allowed based on age and sex. Other than that, however, sick people are able to obtain health insurance for the same price as healthy people. Thus:

- A person who has AIDS would be able to purchase health insurance for the same price as someone who does not.

- People in hospital cancer wards would be able to buy health insurance for the same price as people who do not have cancer.

"Under pure community rating, people who are sick are able to buy health insurance for the same price as people who are healthy."

Community rating has also been implemented in Vermont and is about to be implemented in Minnesota.[23] Variations on the 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 — thus destabilizing the health insurance marketplace.

Misguided Attempts at Reform

Since November of 1991, when Democrat Harris Wofford of Pennsylvania won a U.S. Senate seat by campaigning for health care reform, Washington lawmakers have introduced 79 bills that seek to reform the health care industry.[24] Yet most of the proposed reforms are based on the bad ideas discussed above and would only compound America's health care problems. What follows is a brief description of some of these proposals.

The Jackson Hole Proposal. An idea implicit in most price-fixing proposals is that health insurers should not engage in the same kinds of activities as insurers in other fields. That idea is made explicit in a health care reform proposal developed by Alain Enthoven and other members of the Jackson Hole group,[25] which argues that insurers should not compete on their ability to price and manage risk. Instead, they should compete on their ability to manage health care costs.

Under the proposal, insurers would be forced to charge the same premium to all policyholders of the same age (modified community rating)[26] and to accept all applicants (guaranteed issue). The insurers would compete and try to keep their premiums low by developing skills at managed care.[27] To the degree that there is a trade-off between cost and quality, insurers would compete based on their ability to manage that trade-off in ways pleasing to potential customers.

To see one problem, imagine two competing HMOs. In the first, enrollees can see a primary care physician at the drop of a hat, but there are screening procedures and sometimes lengthy waiting periods for kidney dialysis, heart surgery and other expensive procedures. In the second, dialysis and heart surgery are available when needed, but there are few primary care

physicians. Given a choice, most of us would enroll in the first HMO until we really got sick, then switch to the second. But if everyone did that, the second HMO could not survive financially.[28] Just as is the case with national health insurance, absent a market for real insurance there would be a natural tendency to gravitate away from expensive, lifesaving medical technology.[29]

To see another problem, imagine several HMOs offering identical services. Because they must take all applicants at the same premium, each has an incentive to attract healthy people and avoid people who are likely to generate high health care costs. Since insurers are not allowed to discriminate on the basis of price, they will try to discriminate in other ways — to avoid high-risk applicants and to court low-risk ones. In the attempt to avoid sick people — like a game of musical chairs — some will be more successful than others. The less successful will have higher costs, which will require higher premiums, which will result in fewer customers, etc.[30]

"Under the Jackson Hole proposal, insurers would get out of the business of insurance and into the business of managed care."

For these reasons, the Jackson Hole proposal — and, indeed, any plan that combines community rating with competition — is inherently unstable. In order to keep the market from disintegrating, proponents invariably propose a complex government bureaucracy designed (a) to redistribute funds from profitable to unprofitable insurers and (b) to tightly regulate the content of health insurance policies, preventing insurers from offering higher deductibles or any feature that is likely to attract healthier subscribers. The Jackson Hole reformers propose both approaches.

The Jackson Hole proposal is also unstable because its approach is all-or-nothing. Small changes in the plan — such as changes that are likely in the legislative process — will cause it to fall apart. For example:

- Under the plan, the government would force everyone to purchase health insurance, but if the choice to insure remains voluntary (as in the Bush version of the plan), healthy people who can always buy insurance later if they get sick will drop out as premiums invariably rise. [See the analysis of the Bush plan below.]

- If insurers are allowed to alter their benefit packages and genuinely compete (as the Heritage Foundation seems to advocate),[31] then healthy and sick people will gravitate to different plans and the plans with sicker subscribers will not survive.

Although the Jackson Hole reformers talk about competition, they do not advocate competition among firms in the business of insurance. Indeed, they want to get rid of insurance as such and turn insurers into managers of health care delivery. Thus the Jackson Hole proposal is similar to insisting that auto insurers get out of the business of insurance and get into the business of managing (and perhaps delivering) automobile repairs. Or that fire and casualty insurers get out of the business of insuring homes and into the business of managing home repairs.

Despite inherent problems, the proposal has been influential. It forms the basis for President Bush's health insurance reform proposal, Bill Clinton's proposal, a proposal developed by House Democrats[32] and proposals being considered in California,[33] Maryland[34] and other states.

The Bush Plan. President Bush has endorsed a much-needed reform of our health care system: tax credits for people who purchase their own health insurance. Yet for many people, the financial advantage of the tax credit would be more than wiped out by the effects of the President's plan for community rating.[35] Moreover, other provisions of the president's proposal would assure that almost no healthy person would purchase health insurance.

"Under the Bush plan, people could become insured as they enter a hospital and drop coverage as they leave."

Most proposals for guaranteed issue and community rating 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 picks up the tab. The Bush proposal, by contrast, has no waiting period.

Page 22 of the president's "white paper" on health policy reform 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.[36] Apparently the White House failed to consider that under such a system only sick people would buy health insurance.

The Clinton Plan.[37] Like George Bush, Bill Clinton is convinced that health insurers should be in the managed care business rather than the insurance business. So far, the Clinton plan is long on rhetoric and short on detail. Nonetheless, it clearly endorses guaranteed issue, community rating and competition among insurers based on their ability to manage care.

"The Clinton plan would force providers to ration health care."

There are, however, important differences between the Bush and Clinton plans. Whereas Bush would make the purchase of health insurance voluntary, Clinton would make it mandatory — requiring employers either to pay a tax and shift the responsibility to government or to purchase insurance directly.[38] (Both options, of course, are an alternative to paying wages.) Whereas Bush would grant special tax relief to low-income families, Clinton would not — presumably requiring low-income employees to purchase health insurance (through their employer) whether they can afford to or not.[39] Moreover, Clinton is firmly committed to global budgets — the practice of giving providers a fixed sum and forcing them to ration health care.[40]

The Federal Employee Health Benefits Program (FEHBP). Almost anyone familiar with the health benefits program for federal employees knows that it is in desperate need of reform. This is the opinion of the Office of Personnel Management (OPM), which oversees the program, and of other analysts inside and outside of government. For example, a Towers, Perrin, Foster & Crosby study concluded that "fundamental legislative reform is urgently needed."[41] Nonetheless, the program is interesting for three reasons. First, over the past two decades a steady succession of reformers has called for a program of national health insurance based on the FEHBP system.[42] Second, FEHBP is the model for the Jackson Hole approach.[43] And third, the FEHBP system shows what can go wrong with the Jackson Hole approach.

The program has three main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans;[44] (2) government contributes a fixed amount that can be as much as 75 percent of each employee's premium; and (3) the plans are forced to community rate, charging the same premium for every enrollee. Despite the appearance of competition and the large number of HMO enrollees, the program has not succeeded in controlling costs:

- Over the decade of the 1980s, the federal government's spending on employee health benefits grew at a rate that was over a percentage point faster than for employer-provided health insurance generally (11.22 percent vs. 10.01 percent).

- When spending is adjusted for the number of employees, the federal employees' plan grew more than 25 percent faster than private-sector plans. [See Figure III.]

One reason why FEHBP has not held down costs is that deductibles in the fee-for-service plans are quite low. Even though most private employers

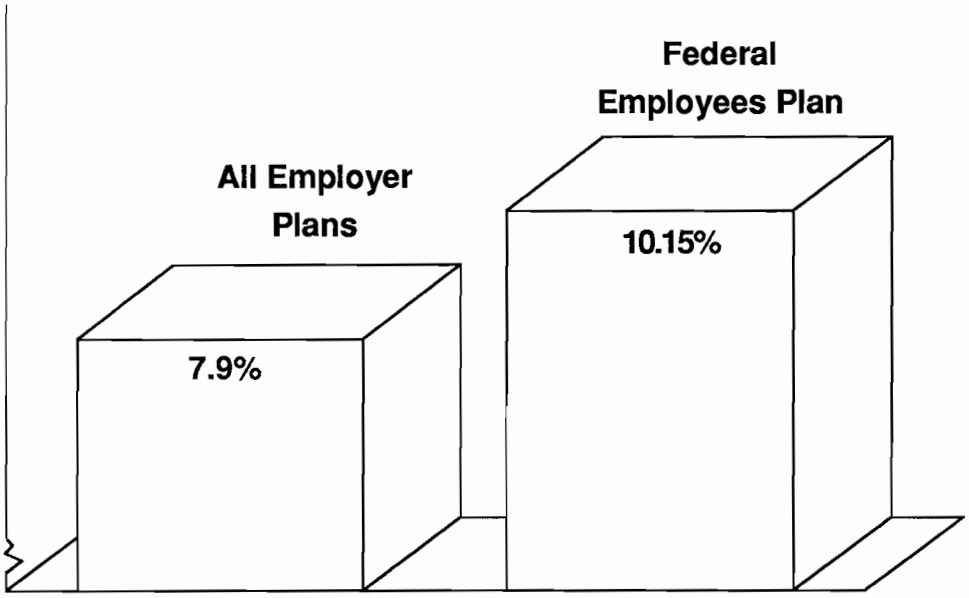
are increasing their deductibles, Blue Cross's FEHBP "high-option" plan has a deductible of $200 and its "standard-option" plan has a deductible of $250. Why are the fee-for-service deductibles so low? Because OPM won't allow Blue Cross, or any other plan, to raise its deductibles or its copayments. The reason? Plans with greater patient cost-sharing are likely to attract younger, healthier employees rather than older, less healthy ones. In fact, OPM rigorously reviews every tiny change in plan design to make sure that the change does not appeal to good risks rather than bad ones. For example, it won't allow a plan to include coverage for teeth cleaning but omit coverage for dentures — on the theory that such a change would make the plan more attractive to younger people.

"The cost of the federal employees' plan has grown 25 percent faster than costs for employer plans generally."

FIGURE III

Annual Rate of Growth in Per Capita Health Care Costs[1]

1980-1990



[1]Annual rate of growth in spending per full-time equivalent employee.

"Although the federal employees' plan gives the appearance of consumer choice, real competition is prohibited."

Even with all of this oversight, outside analysts say that virtually all the competition that exists is competition for good risks — not competition in the sense in which Jackson Hole advocates imagine.[45] And it is precisely the adverse selection that results because insurers cannot price risk accurately that has caused Aetna, the only systemwide insurer other then Blue Cross, to leave FEHBP.[46] Despite glowing descriptions by its defenders,[47] the FEHBP has none of the desirable characteristics of a competitive system:

- When competition is working, price is supposed to reflect value; yet although there is a 42 percent difference in value of benefits between highest and lowest option plans, the premiums differ by 264 percent.[48]

- In order for competition to work, people have to be able to perceive differences in value; yet despite the fact that there is virtually no difference between the Blue Cross high-option and standard-option plans, many federal employees pay four times as much for the former — believing incorrectly that they are getting four times more value.[49]

- Whereas workable competition should naturally lead to customer-pleasing innovations, none of the FEHBP plans are allowed to offer a Flexible Spending Account — a highly valued and common feature of private employer-provided health insurance.[50]

- Whereas the Jackson Hole group imagined that insurers in such a system would compete based on their ability to manage care, the fee-for-service plans now instituting managed care are doing so not because they see it as good business but because Congress passed a law requiring it.[51]

The Obstacle to Sensible Reforms: Proponents of Managed Care

As noted above, sensible reform of private health insurance has been prevented because all too often the reformers have hidden motives. Rather than encourage a workable market for health insurance, misguided reformers want to get rid of *health insurance* altogether and replace it with *managed care*. Instead of seeing if managed care can survive the market test in competition with its alternatives, some of its advocates want to use government to

automatically declare it the winner. Is it a good idea to get rid of health insurance and force insurers to compete based on their ability to manage care? Let's take a closer look.

"Some advocates want government to declare managed care the winner and avoid having it compete against alternatives in the marketplace."

What Is Managed Care? Traditionally, "managed care" meant combining paying for health care with providing health care — typically in a Health Maintenance Organization (HMO).[52] More recently, the term has been applied to a whole range of activities whose goal is to make medical care more cost-effective. In all its guises, managed care means interfering with the conventional doctor-patient relationship.

Can Managed Care Save Money Without Reducing the Quality of Patient Care? Most studies show that HMOs save money by substituting less expensive for more expensive therapies. For example, physician therapy and drug therapy are both less expensive than hospital therapy. The next generation of cost management techniques, however, seeks to subject *every* medical decision to cost-benefit analysis. For example, the American Medical Association and the Rand Corporation are working to develop "practice guidelines" for physicians and Congress has mandated that the Department of Health and Human Services draw up similar guidelines. The goal is the development of "computerized protocols" that will tell physicians what they should do when confronted with certain patient symptoms and conditions.[53]

Will the guidelines work? That's not clear. Many people believe they will be a waste of money. Some argue that their development is such a lengthy process that computerized protocols will always be years behind state-of-the-art medical practice. Others say that such protocols assume that computer programs will usually make better decisions than the physicians who meet and talk to patients. Studies have not borne out this assumption. In one test, judgments of general practitioners were matched with three different computerized protocols in the treatment of patients with abdominal pain; the GPs outperformed the protocols in every test.[54]

"Studies have not borne out the benefits claimed for computerized protocols."

Alternatives to Managed Care. Most advocates of managed care envision a world in which a bureaucracy tells physicians and patients what to do. The techniques of managed care would form the basis of these instructions. Yet if the techniques really worked and were of value, they would likely be adopted voluntarily in the marketplace — without the need for health care "managers." For example, if workable computerized protocols were available to physicians, they might be valuable tools. Physicians could consult

the computer, then substitute their own judgment where appropriate. Less complicated protocols might become available to patients for use on their home computers, giving advice on whether to see a physician, for example.

Making Decisions through the Market. In other areas of economic life, we subject ideas to the market test and allow competition to determine which ones survive. That's a good practice to follow in health care as well. Whether managed care should supplement health insurance or replace it should be determined by the market, not by politicians. Similarly, which managed care techniques are valuable and which ones aren't is best determined by competition rather than by fiat.

Managed Care and Health Care Rationing. If computerized protocols and practice guidelines were used to control the behavior of physicians and patients, they could threaten the quality of medical care. And, unfortunately, the threat is real. Rand Corporation researcher Robert Brook has argued that Rand's techniques can be used to ration health care under the Medicare system, if Medicare funds run short.[55] And William Schwartz (Tufts) and Daniel Mendelson (Levin-IFC) argue that managed care has already achieved most of the savings that are achievable by reducing hospitalization. The only way for managed care to control the long-term rise in health care costs, they argue, is to deny people access to expensive but useful technology.[56]

Conclusion

"Solving real problems requires a competitive market for real health insurance."

For policymakers interested in encouraging a workable system of private health insurance for individuals and small groups, there are a number of potentially useful reforms. These include making health insurance personal and portable and guaranteeing the right of people to renew their policies at reasonable prices.

Unfortunately, genuine reform has been sidetracked by those who have a different agenda: eliminating the market for health insurance and replacing it with a market for managed care. These "reform" proposals would impose price controls and make it impossible for people to purchase health insurance for actuarially fair premiums. Yet experience tells us that price fixing and regulation are not the answer.

If legislators wish to enact reforms that satisfy human needs in an efficient way, they must search for ways to empower people and allow them to use their intelligence, their creativity and their innovative ability to solve problems in freely competitive markets.

John C. Goodman

Footnotes

[1] Polls show that about 30 percent of employees experience "job lock" — a condition under which they fear that switching jobs could cause them to lose their health insurance benefits. Eric Eckholm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.

[2] See the discussion in the NCPA Task Force Report, "Solving America's Health Care Crisis: An Agenda for Change," National Center For Policy Analysis, NCPA Policy Report No. 151, May 1990.

[3] See the discussion in 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.

[4] To the extent that employees pay part of the premium, most large companies charge every employee the same premium, regardless of age, location, job task — or any other indicator of risk. As a result, these companies face some of the same problems caused by community rating in a health insurance market. Under the system, older workers view health care as cheap and pressure the employer to provide more of it. Younger workers view it as expensive and increasingly are declining coverage, even though their premium is partly "subsidized." One of the fastest-growing segments of the insurance market is for individual policies for dependents of insured workers — who apparently find that health insurance outside the company is cheaper than the artificial premiums employers charge them.

[5] See the American Legislative Exchange Council's (ALEC) model legislation, "The Health Insurance Reform Act for Small Business Coverage."

[6] The amount of the tax subsidy should vary with income in the manner described later in the text.

[7] Under the provisions of the Consolidated Budget Reconciliation Act (COBRA), employees are entitled to continue coverage for a limited period of time after they leave an employer.

[8] In a recent and highly publicized case, H & H Music Company of Houston, TX, reduced its lifetime benefit limit from $1 million to $5,000 after learning that one of its employees had tested positive for the AIDS virus. The employee sued the company but lost the suit because the employer was self-insured and therefore not subject to federal regulations. The case is currently before the Supreme Court. See Terry Giesel, "Self-Insurers Can Limit AIDS Benefits: Court," *Business Insurance*, August 6, 1990, pp. 1, 27-28.

[9] See the discussion in "Solving America's Health Care Crisis."

[10] For an extensive analysis of the concept, see John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts."

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

[12] Source: Golden Rule Insurance Company.

[13] 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 forgone 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 forgone coverage is 80 percent x ($2,500 - $250) = $1,800.

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

[16] Karen M. Beauregard, "Persons Denied Private Health Insurance Due to Poor Health," Agency for Health Care Policy and Research, Public Health Service, AHCPR Report No. 92-0016, December 1991.

[17] For small group health insurance reform (which does not include individual and family policies), here are other estimates of the likely increase in premiums:

- The Health Insurance Association of America (HIAA) estimates that its proposed small group reform would raise premiums by 2.5 percent to 4.0 percent, but this estimate makes unrealistically low assumptions about the numbers of sick people who would buy health insurance and the numbers of healthy people who would drop their coverage. See HIAA memo dated August 29, 1991.

- Community Mutual Insurance Company (a Blue Cross/Blue Shield company) estimates that the HIAA plan would increase premiums by 20 to 25 percent. See "Perspective on Small Group Market Reform," a study conducted for Community Mutual Insurance Company, September 1991.

- Tillinghast estimates that a similar plan in the state of Ohio would increase premiums by 11 to 47 percent. See Ted A. Lyle and Janet M. Carstens, "Actuarial Review of Proposed Small Group Reform Legislation in Ohio," a study conducted for Community Mutual Insurance Company, November 29, 1991.

- Golden Rule Insurance Company's actual experience was that "guaranteed issue" policies led to an increase in claims costs of over 50 percent in the second year and 30 to 35 percent thereafter. Golden Rule offered no-questions-asked health insurance policies to employers with 10 to 25 employees. There was a surcharge for the no-questions-asked groups that ranged 15 to 20 percent above what the same group could get if they provided health information in their application. There were also some restrictions.

[18] Stephen D. Brink, James C. Modaff and Steven J. Sherman (Milliman & Robertson, Inc.), "Variation by Duration in Small Group Medical Insurance Claims," Society of Actuaries Research Report, September 5, 1991.

[19] These are results for groups of size 1 to 25. For a smaller group, say 2 to 9, the cost of guaranteed-issue insurance was twice as high.

[20] This cost is adjusted for the drop-off in the number of policyholders over time.

[21] A standard industry assumption is that the elasticity of demand for health insurance is 0.5. The NCPA/Fiscal Associates Health Care model estimates the elasticity at 0.65.

[22] Sarah Lyall, "Albany Will Pass Bill to Overhaul Health Insurance," *New York Times*, July 2, 1992.

[23] See Gina Kolata, "An Old Health Insurance Idea Returns: Sharing the Risk," *New York Times*, June 28, 1992.

[24] Dana Priest, "Health Care Industry's Insurance Policy on Reform: Lobbyists," *Washington Post*, August 13, 1992.

[25] Other members of the group include Paul Ellwood (who is credited with coining the term "Health Maintenance Organization" and who has actively promoted the concept) and Lynn Etheredge. The original principles of this approach were laid out in Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, Mass: Addison-Wesley, 1980). For a more recent statement, see Paul Ellwood et al., "The 21st-Century American Health System: A Proposal for Reform," September 3-4, 1991. Unpublished manuscript.

[26] Premiums would vary by age — not because the Jackson Hole group finds the practice fair or desirable but because they judge it necessary in order to induce young people to buy insurance.

[27] What has traditionally been called "managed care" is now frequently referred to as "coordinated care."

[28] The HMO would be receiving premiums only from people who were about to undergo expensive medical procedures. Thus the average premium would have to equal the average cost of the procedures. It is precisely because most people cannot easily bear such a financial burden that health insurance is desirable in the first place.

[29] In the absence of a competitive market, people living in countries with national health insurance perversely may find it in their rational self-interest to vote for a policy of increased primary care services funded by a reduction in acute care services. See the analysis in 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.

[30] Note that this problem arises only because of price controls. Insurers have no reason to avoid applicants if each person who enters an insurance pool pays a premium that reflects the expected cost and risk the person adds to the pool.

[31] See Robert E. Moffit, "Why the Maryland Consumer Choice Health Plan Could Be a Model for Health Care Reform," Heritage Foundation, Backgrounder No. 902, June 17, 1992; see also Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis; Part II: The Heritage Consumer Choice Health Plan," Heritage Foundation, March 5, 1992.

[32] The proposal, now being drafted, was developed by Charles Stenholm (D-TX), Jim Cooper (D-TN) and Michael Andrews (D-TX).

[33] The California proposal has been introduced by the state's insurance commissioner, John Garamendi. See Lou Cannon, "California Official Offers Health Plan," *Washington Post*, February 13, 1992; and "Good Health — and Good Politics," *New York Times*, June 27, 1992. On the connection of the California plan to Alain Enthoven, see Ken McDonnel, Michael Anzick

and William Custer, "State Initiatives in Health Care Reform," Employee Benefit Research Institute, EBRI Issue Brief No. 127, June/July 1992.

[34] A bill proposed by Maryland state legislator Casper R. Taylor, Jr. (H.R.376) was based on a proposal developed by Jack A. Meyer and Sharon Silow-Carroll of New Directions for Policy and Carl J. Sardegna of Maryland Blue Cross/Blue Shield. This proposal, in turn, was heavily influenced by the ideas of Alain Enthoven. See Meyer, Silow-Carroll and Sardegna, "Universal Access to Health Care: A Comprehensive Tax-Based Approach," *Archives of Internal Medicine*, Vol. 151, 1991, pp. 917-22.

[35] "The 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)

[36]"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." "The 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.

[37] Bill Clinton, "Putting People First: A National Economic Strategy," Bill Clinton for President Committee, June 21, 1992.

[38]See "Democratic Ticket Holds Back on Health Care Reform Details," *American Medical News*, August 3, 1992.

[39] "Putting People First" implies that there will be (probably for small businesses) short-term but not long-term tax relief.

[40] Although Clinton does not use the word "rationing," he promises that the money providers will have to spend will grow no faster than aftertax personal income, regardless of the cost of health care resources.

[41] Cited in Janet P. Lundy, "The Federal Employees Health Benefits Program," Congressional Research Service, CRS Issue Brief, updated June 11, 1992.

[42] See the summary in Enthoven, *Health Plan*, pp. 114-115.

[43] Ibid., pp. 82-84 and p. 119.

[44] The Blue Cross high-option and standard-option fee-for-service plans are available to all federal employees. Seven additional "open" fee-for-service plans sponsored by unions or employee organizations also are available to all federal employees. Health Maintenance Organizations (HMOs), which are geographically based and thus available only to those living in specific areas, make up the vast majority of FEHBP options.

[45] "Statement of the Consultants of the Committee on Post Office and Civil Service before the Subcommittee on Compensation and Employee Benefits," May 20, 1992. Testimony before the House Subcommittee. [Hereinafter referred to as "Consultants' Statement."]

[46] Lundy, "The Federal Employees Health Benefits Program," p. 7.

[47] The Heritage Foundation has called the FEHBP a "prototype" for national health care reform and recommended the Taylor plan in Maryland as a "model" for the states. See Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation, Backgrounder No. 878, February 6, 1992. See also Robert E. Moffit, "Surprise! A Government Health Plan That Works," *Wall Street Journal*, April 2, 1992; and Carl J. Sardegna, "How the Maryland Health Plan Is a Model for the Nation," Heritage Foundation, Heritage Lectures No. 392, May 27, 1992.

[48] Lundy, "The Federal Employees Health Benefits Program," p. 7.

[49] The Blue Cross high-option plan carries a $200 calendar-year deductible versus a $250 deductible for the standard-option plan. The high-option plan generally requires a 20 percent copayment versus a 25 percent copayment for the standard option and offers greater coverage for mental health care. For those small differences, a family pays $4,396 annually for the high-option plan versus $1,035 for a standard-option plan.

[50] In many private employer plans, employees may deposit pretax dollars in a Flexible Spending Account (FSA), from which to purchase medical care not covered by the employer's health insurance policy. Federal employees do not have this right. See "Consultant's Statement," p. 21.

[51] OBRA (1990) requires all fee-for-service plans to include preadmission certification and large-case management beginning in 1991. See Lundy, "The Federal Employees Health Benefits Program," p. 6.

[52] For a review of the effects of HMOs, see John K. Inglehart, "The American Health Care System: Managed Care," *New England Journal of Medicine*, Vol. 327, No. 10, September 3, 1992, pp. 742-47.

[53] See the discussion in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

[54] Jane Orient, "An Evaluation of Abdominal Pain: Clinicians' Performance Compared with Three Protocols," *Southern Medical Journal* 79, No. 7, July 1986, pp. 793-9.

[55] Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?" *Journal of the American Medical Association* 262, No. 21, December 1, 1989, p. 3027.

[56] William B. Schwartz and Daniel N. Mendelson, "Why Managed Care Cannot Contain Hospital Costs," *Health Affairs*, Summer 1992.

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