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For people with limited time and a need to know.

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The Health Policy Debate: Options for Reform

"Almost everyone in Congress is seeking an alternative to the Clinton plan."

Both the Congress and the American people seem to have already rejected President Clinton's health reform blueprint.[1] A large bloc of voters, perhaps a majority, is vehemently opposed to the plan. Many others are confused or skeptical. In Congress, staunch supporters of the president's proposal are rare. The key congressional committees are all considering variations or alternatives. If any health reform plan passes this year, it will be quite different from what the president originally proposed.

As Congress attempts to piece together reform legislation, many policy questions are unresolved. Specifically:

- Should the legislation include employer mandates or individual mandates?
- Should the legislation include a government-defined benefits package?
- Should the goal of reform be universal coverage?
- Should the legislation prohibit preexisting conditions limitations?
- Should the legislation require community rating?
- Should managed competition be the model for reform?
- Should the legislation include regional alliances?
- Should the legislation impose global budgets and price controls?
- Should the legislation include Medical Savings Accounts?
- Should individual tax deductions be allowed for the purchase of health insurance?
- Should the legislation create tax credits for low-income families?
- Should the legislation provide for risk pools?

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This backgrounder addresses and answers each question. It also explains why intelligent reform would solve our most important health care problems, while misguided reform would make the problems worse.

Do We Need Mandates?

The Clinton plan would require employers to pay 80 percent of the cost of health insurance for each employee. Other plans would force individuals to purchase insurance whether they want to or not. Are such mandates needed?

The Uneasy Case for Mandates. The primary rationale for an employer or individual mandate is to achieve universal coverage by forcing everyone to buy insurance. But is that the best way to achieve the goal? Currently 85 percent of the population is insured at any one time and 15 percent is uninsured. A mandate would require government regulation of the insurance coverage of the 85 percent, but it would not assure coverage of the remaining 15 percent. As we shall see below, a substantial number of people would continue to be uninsured. A mandate would impose substantial costs on the great majority of people in return for a marginal gain.

"A mandate would regulate the 85 percent of the population that is already insured without assuring coverage of the remaining 15 percent."

Some argue that without mandates some people would choose to remain uninsured and would rely on the rest of us to pay — through taxes or cost shifting — for their care. But the amount of such private uncompensated care is currently between $10 billion and $15 billion per year, less than 2 percent of total health care spending.[2] Two to three times that amount is estimated to be shifted onto private medical bills because Medicare and Medicaid underpay doctors and hospitals.[3] Moreover, most uncompensated care is for the poor, and under any scenario the cost of their care would be paid by the rest of society.

There are a number of ways to substantially reduce the number of uninsured people without mandates. These include tax relief for people who purchase their own insurance, tax subsidies for low-income families, Medical Savings Accounts (which can be used to pay premiums when people are between jobs), portability and guaranteed renewability of insurance. Indeed, we can create virtual universal coverage without any mandate whatsoever. [See the discussion below.]

An Employer Mandate Is Really an Employee Mandate. Economists generally agree that fringe benefits are earned by workers and that they substitute for wages. Employers cannot afford to pay more in total compensation than the value of a worker's output. So if labor costs go up because of mandates, the employer usually is forced to reduce wages by an offsetting

amount. Requiring employers to provide health insurance, therefore, is tantamount to forcing workers to take health insurance rather than wages. Nominally, the mandates apply to employers. Actually, they force workers to purchase health insurance whether they want to or not.

Lost Wages. Several studies have estimated the magnitude of the wage loss that would result under the Clinton plan:

- Harvard professor Martin Feldstein, who serves as president of the National Bureau of Economic Research, estimates that the Clinton plan would result in a 6.4 percent reduction in average wages by 1997, a net loss of $115 billion for the year.[4]
- Labor economists June and Dave O'Neill of Baruch College estimate a wage reduction under the plan of about 6 percent for uninsured workers.[5]
- Ohio State University economists Richard Vedder and Lowell Gallaway estimate that the plan would cause wage reductions of about $94 billion per year, with a total loss of personal income of $112 billion.[6]
- A study by the DRI/McGraw Hill consulting firm estimates wage losses under the Clinton plan at almost $82 billion per year.[7]
- Economists Lawrence Hunter of the Joint Economic Committee and Morgan Reynolds of Texas A & M University estimate annual wage losses of about $106 billion.[8]
- Using the National Center for Policy Analysis/Fiscal Associates Health Care Model, Gary and Aldona Robbins estimate wage losses of $69 billion per year by 1998.[9]

Why Mandates Would Cost Jobs. Virtually all studies of mandates conclude that they destroy jobs. Even the Clinton administration agrees. When the government forces people to have less take-home income to pay for health insurance they may not want, working becomes less attractive. This is especially true for marginal workers — teenagers, working wives and the elderly — who may already be covered under some other policy. In addition, employers may not be able to substitute lower wages for health insurance for some employees because of the minimum wage law and other legal barriers. In that case, workers would simply lose their jobs. Moreover, to the extent that the cost of mandated health insurance is not paid by lower wages, it is a tax on capital. Taxes on capital reduce the amount of capital, which in turn reduces the demand for labor.

"An employer mandate would cause about $100 billion per year in lost wages."

All mandates cost jobs. But some are worse than others. The Clinton plan's mandates would be especially onerous because:[10]

- Workers such as teenagers, part-time workers, two-worker families and elderly workers on Medicare would have to pay again for coverage they already have.
- The requirement of community rating would double the cost of health insurance for younger workers, who tend to place the lowest value on health insurance.
- The plan would impose a disguised 7.9 percent tax on labor income.
- Although there are subsidies for small businesses with low-income employees, the taxes needed to fund the subsidies also would cost jobs.

The Clinton Administration's Estimates of Lost Jobs. The Clinton administration estimates that its health reform plan would cost 600,000 jobs but says that most of the losses would be offset by job gains elsewhere in the economy.[11] The administration's view has modest support among outside analysts. Economist Alan Krueger of Princeton University believes that only about 200,000 jobs would be lost.[12] The Congressional Budget Office claims that the administration's proposal would "probably have only a small effect on low-wage employment."[13] These administration-friendly analysts believe job loss would be minimal because the additional cost of health insurance premiums would be largely absorbed by lower wages and slower wage growth, thereby leaving labor costs essentially unchanged.

"The administration estimates that its plan would cost 600,000 jobs."

More Realistic Estimates of Lost Jobs. Eight major independent studies of the impact of employer mandates estimate job losses ranging from a low of 600,000 (the Rand Corporation) to a high of 3.8 million (CONSAD Research Corporation). The average predicted loss is 1 million jobs. [See Table I.] Here are some specifics:

- Labor economists June and Dave O'Neill estimate that Clinton's employer mandate would cause as many as 2.1 million workers to lose their jobs. [14]
- Economists Richard Vedder and Lowell Gallaway estimate that the Clinton plan would destroy 1,021,000 jobs. [15]
- Economists Lawrence Hunter and Morgan Reynolds estimate that the Clinton plan would eliminate as many as 1,151,000 jobs. [16]
- DRI/McGraw Hill estimates the likely job loss from the Clinton plan at 659,000 jobs, with a possible job loss of 908,000.[17]

"An employer mandate would cost about one million jobs."

TABLE I

Estimated Job Loss from the Clinton Health Plan

Study	Probable Job Loss	Potential Job Loss
ALEC	1.0 million	—
State of California	2.6 million	3.7 million
DRI/McGraw-Hill	659,000	908,000
Employment Policies Institute	780,000 - 890,000	2.3 million
JEC/GOP	710,000	807,000 - 1.2 million
NCPA/Fiscal Associates	*738,000	—
NFIB/CONSAD	850,000	3.8 million
RAND	600,000	—
Average	1.0 million	2.1 million

* The NCPA study also includes an "optimistic" forecast of 677,000 jobs lost.

- A study by the CONSAD research firm found probable job losses from the Clinton plan of 850,000 and potential losses of 3.8 million. [18]
- A study by the Employment Policies Institute projected job losses under the Clinton plan as high as 2.3 million.[19]

The Joint Economic Committee of Congress has cataloged 40 studies of employer mandates. Only the eight studies examined here used econometric models to produce specific numbers on job loss. However, all 40 came to the same general conclusion: employer mandates destroy jobs and reduce wages.

Estimates of the Economic Impact. Lost jobs mean less output and less income for the country. Four of the major studies also consider the impact of an employer mandate on the economy as a whole. Their predictions:

- DRI/McGraw-Hill: gross domestic product (GDP) will be down by $53 million in the year 2000.
- The National Center for Policy Analysis: GDP will be down by $90 billion in 1998.
- American Legislative Exchange Council: personal income will be down $112 billion by 1998.
- State of California: GDP will cumulatively decrease $224 billion from 1995 through 1998.

An Invitation to Government Control of the Health Care System. Under the mandates being considered, the government would define the health insurance benefits package all Americans must purchase. This would be an open invitation for every special interest group — from chiropractors to naturopaths — to lobby for inclusion in the package. As the mandated benefits package became more bloated and more costly, even the most conservative voters would demand that government intervene to keep the premiums down. But controls on premiums would inevitably lead to controls on doctor and hospital services. Ultimately, then, mandates would encourage government control of the entire health care system.

"An employer mandate would cost about $900 per family per year in lost output."

The Difference Between an Employer Mandate and an Individual Mandate. From a technical and conceptual viewpoint, there is no difference between an employer mandate and an individual mandate. Either employers are required to substitute health insurance for wages, or employees are required to substitute health insurance for wages or other income. The net result is the same.

As a practical matter, however, those who favor employer mandates usually rely on the economic fiction that the burden of the mandate falls on employers. Their proposals typically make no distinction between high- and low-income employees.[20] Under these proposals, the full weight of the mandate on low-income employees would cause draconian cuts in wages and/or lost jobs.

Those who favor individual mandates are aware that employees bear the full burden of any mandate. As a result, their proposals tend to include subsidies or tax relief to ease the burden on low-income employees.[21] Although jobs would be lost, the harm would be less than that produced by employer mandates. Proposals to enact individual mandates, therefore, often make more economic sense — and perhaps for that reason they appeal to more Republicans. It would be a mistake for Republicans to endorse this option, however.

The Politics of Mandates. As a political matter, an individual mandate would inevitably lose to an employer mandate. Imagine the average

voter's choice. As *Newsweek* columnist Eleanor Clift said recently, "If the Republicans say you have to pay for health insurance and the Democrats say your employer has to pay for it, the Republicans lose."[22]

Most voters are not economists. Despite the economic arguments that an employer mandate would cost jobs and wages, voters would tend to remain confused and uncertain and to conclude that opponents of such mandates are protecting big business. Republicans are particularly vulnerable to this charge. For them, opposing an employer mandate and/or supporting an individual mandate would raise the class warfare issue again, framing the issue in exactly the wrong terms.

A mandate is perfectly analogous to a tax. You cannot defeat an employer tax by proposing to put the tax on the workers instead. You can only defeat it by opposing new taxes across the board. Similarly, you can only defeat an employer mandate by opposing mandates for everyone. Indeed, support for an individual mandate sharply increases the prospects for passage of an employer mandate. If everyone agrees that some mandate is necessary and the only question is which one, the political process will favor putting the mandate on employers, not workers.

The Clinton administration understands this political calculus. Hillary Rodham Clinton recently stated on national television:

> I think that if the debate in Congress is between our approach, which is an employer-employee shared responsibility... and Senator Chafee's approach, which has an individual responsibility, I think that's the right debate.[23]

Do We Need a Government-Defined Health Insurance Benefits Package?[24]

"Government control of the content of health insurance plans would restrict consumer choice."

The Clinton plan and most proposed alternatives specify a particular government-defined benefits package for everyone. The Clinton plan calls for low-deductible coverage and details a broad range of required benefits, including abortion, drug and alcohol rehabilitation, mental health counseling, prescription drugs, dental care, vision care, hearing care and more. Is this necessary or desirable?

Restricting Freedom of Choice. A government-defined benefits package would necessarily restrict freedom of choice. In particular, it would force consumers to pay for many expensive, nonessential benefits they may not want.[25] For example, teetotalers don't need coverage for alcoholism treatment. People who don't take illegal drugs do not need coverage for drug abuse treatment. And neither men, nor women past childbearing age, need

maternity benefits. Yet under the Clinton plan and many other plans, everyone would be forced to pay for these benefits as part of a comprehensive package.

At the same time, everyone would be denied coverage for benefits that are excluded from the package. People who want to replace coverage they regard as worthless with, say, more extensive long-term care benefits would not be allowed to do so.

Encouraging Too Much Third-Party Payment.[26] Most proposals that mandate a benefits package require low deductibles and deductible waivers for certain procedures. The Clinton plan, for example, requires an annual deductible of $200 per individual and $400 for families — lower than the deductible most families currently have. And the plan requires that the deductible be waived for many services including abortions, contraceptives, mammograms, certain vaccinations and other diagnostic tests. If enacted, these waivers would exacerbate the problem of third-party payment, encouraging patients to overconsume medical resources and obtain wasteful, unnecessary care because someone else would be paying the bill. Such expanded third-party coverage would add to the trend of rapidly rising health costs.

Lessons from the States. If the content of everyone's health insurance benefits package were determined through the political process, special interests would be able over time to force the general public to buy more and more nonessential benefits. This would add further unnecessary costs, as experience in the states proves.

"Special interests would try to get everything from acupuncture to in vitro fertilization into the package."

State-mandated health insurance benefits laws tell insurers what services and providers they must cover in order to sell health insurance in a state. Although they nominally restrict insurers' behavior, the laws effectively limit consumers' choices. They force people either to purchase a Cadillac plan — bloated with extra benefits — or to remain uninsured.

Mandated benefits laws cover diseases ranging from mental illness to alcoholism and drug abuse, services ranging from acupuncture to in vitro fertilization and 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. In 1965 there were only eight mandated health insurance benefits laws in the United States. Today, there are more than a thousand.[27]

Although the same objectives can be achieved in much less harmful ways, state mandates are pricing millions of people out of the market for health insurance:

- According to one study, mandated coverage increases premiums by 6-8 percent for substance abuse, 10-13 percent for outpatient mental health care and as much as 21 percent for psychiatric hospital care for employee dependents.[28]
- According to another study, one out of every four uninsured people has been priced out of the market by state-mandated benefits laws.[29]

"Mandated health insurance benefits have already priced one of every four uninsured people out of the market."

The Politics of Benefits Packages. For Republican opponents of the Clinton plan, advancing an alternative that includes a government-defined benefits package frames the issue in a losing way. These Republicans will find themselves in a bidding war with the Democrats, who will contrast their broader packages (mostly paid for, they will say, by employers) with the narrower Republican package. Republicans will appear to be heartless naysayers, once again trying to protect big business from higher costs and to deny better benefits to working people. This is a battle that Republicans cannot win.

"Republicans who favor government-defined benefit packages will lose in a bidding war with Democrats."

Another problem is that once the government begins to specify the content of an insurance plan, then the question of whether abortion will be covered is unavoidable. Pro-life Republicans supporting a government-defined benefits package would be unwittingly undermining their pro-life constituencies, even if abortion were not included in the package they sponsored. That is because the pro-life community would have to fight against coverage for abortion every year thereafter, in a battle that would drain their resources, with nothing to gain and great potential for ultimate defeat. Moreover, no Republican should relish annual, high-profile abortion votes that would inevitably alienate potential supporters on both sides of the abortion question.

These losing battles can be avoided only by opposing the government specification of a standard uniform benefits package in the first place and favoring consumer choice instead. The issue then becomes not who favors generous benefits or whether abortion coverage is in, but who prefers government control over consumer choice. This frames the issue in a winning way for Republican opponents of the Clinton plan.

A government-defined benefits package is necessary only for reforms based on an employer or individual mandate, because these mandates usually require the government to specify exactly what benefits it is forcing employers or workers to buy. For opponents of mandates, there is no sound policy reason why the government must specify standard benefits.

Should Universal Coverage Be the Goal?

Bill Clinton has said that universal coverage is the goal of his health care reform proposal and has threatened to veto any health reform bill that does not provide it. But is universal coverage a reasonable goal of reform or a valid test of reform's success?

Why Universal Coverage Through Mandates Is Unattainable. Many have assumed that universal coverage is impossible without a mandate — one either requiring individuals to buy insurance or their employers to purchase it for them. But even with mandates there are three reasons why universal coverage cannot be achieved.

First, history shows that it's virtually impossible to force everyone to purchase insurance, even at highly subsidized rates. For example:

- At least 41 states and the District of Columbia require motorists to carry auto liability insurance. However, about one in seven drivers remains uninsured (ironically, about the same fraction as those who lack health insurance).[30]
- Hawaii has 20 years of experience with a law that mandates health insurance through the workplace, yet the number of uninsured Hawaiians ranges from the state's own estimate of about 6 percent to the Census Bureau's estimate of 11 percent. The latter figure exceeds that of several states without mandates.[31]
- Even Canada's vaunted health care system has not achieved universal coverage; for example, an estimated 2 to 5 percent of the population of British Columbia — between 70,000 and 170,000 people — fail to pay premiums and thus are uninsured.[32]

"Even in Canada, some people are uninsured."

Why doesn't coercion work? In principle, the government could fine or jail people who fail to purchase their own health insurance. In practice, these sanctions would be politically difficult and administratively expensive.

Second, most uninsured spells are temporary and neither the Clinton plan nor any other plan provides a credible solution to the problem of temporary lack of insurance. The latest estimates suggest that 58 million are uninsured for at least one month during an average year.[33] Figure I shows that:

- Half of all uninsured spells last less than six months.
- Three-fourths of the uninsured get insurance within 12 months.
- Only 18 percent of all uninsured spells last more than two years.

In general, the Clinton plan would subject those who fail to obtain insurance to fines of up to $5,000 or three times the premiums they failed to pay, whichever is greater.[34] But since individuals would have to report their insurance status on their tax return only once a year, there would be ample opportunity for people to be uninsured when they were not someone else's employee. And for the same reason that the IRS allows people to file late returns, the government probably would do nothing to the uninsured who managed to obtain insurance by the time of tax filing. No one wants to see the courts bogged down with a whole new category of cases.

Finally, among the chronically uninsured are those who don't file income tax returns and those who don't even have addresses. When they show up at hospitals, they would almost certainly get care under the Clinton plan whether they're insured or not, and the administration would surely decide it's cheaper to care for them without hassling them about insurance.

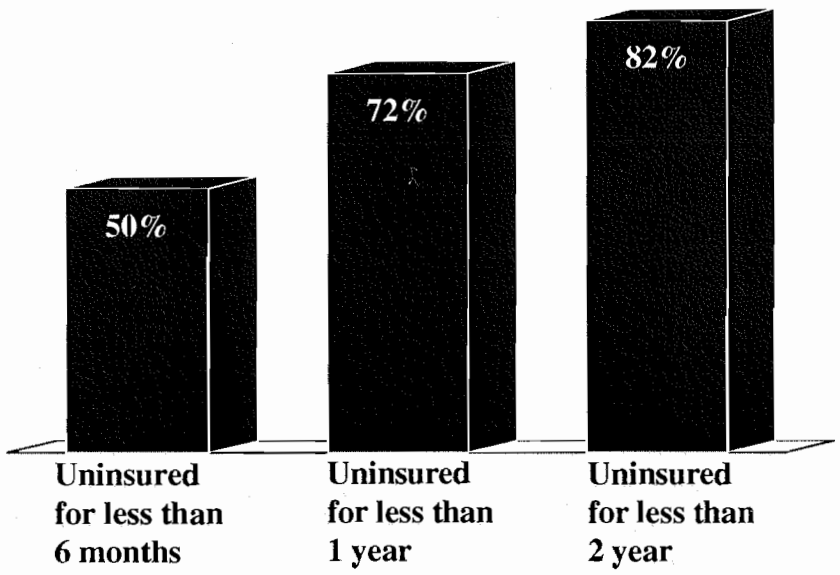
How to Achieve Universal Coverage Without Mandates. Fortunately, there is a better way to achieve universal coverage than to impose any type of mandate. Government can make health insurance affordable for every family through a system of tax credits. It can establish tax fairness, by treat-

"Most people are uninsured for less than a year."

FIGURE I

How Long Do People Go Without Health Insurance?

(millions)



Source: Katherine Swartz, "Counting Uninsured Americans," Kaiser Health Reform Project, Henry J. Kaiser Family Foundation, January 1994.

Universal Coverage Without Mandates

The problem with the existing system is not that the uninsured are denied health care. Uninsured patients are routinely treated at our nation's hospitals. Nor is the problem that the uninsured are getting a free ride at everyone else's expense. Precisely because they do not receive the average tax subsidy enjoyed by those who have employer-provided insurance, the uninsured pay higher taxes — perhaps as much as the amount of free hospital care they consume each year.

Instead, there are two other problems. First, the tax subsidy for health insurance is arbitrary because it excludes people who purchase health insurance on their own. Second, under the current system most of the additional taxes paid by the uninsured go to Washington rather than to the local hospitals that provide the free care. How can we solve these problems?

Refundable Tax Credits. Part of the solution is to offer everyone a tax subsidy for the purchase of health insurance, with higher subsidies for lower-income families. For individual purchases of health insurance, a tax credit would be entered on individual income tax returns. For those with very low incomes, there would be refundable tax credits — with government directly subsidizing a portion of the health insurance premium.

Access to Health Care. Even faced with a generous subsidy, some people would opt to be uninsured. If they did so, they would pay higher taxes, which would be sent back to local communities to cover the cost of their health care. Existing laws generally require hospitals to provide emergency care to patients, regardless of ability to pay. With the new source of funds proposed here, we could liberalize access to health care for uninsured, indigent patients. But "free" care is unlikely to be perceived as being as desirable as "purchased" care and may involve considerable health care rationing.

Under this proposal, no one would be required to purchase health insurance. Those who chose not to do so would be forced to rely on charity care if they could not pay their medical bills. Thus people would have incentives to purchase health insurance — to protect their assets, to acquire the quality of health care they want and to be free to exercise choice in the medical marketplace.

Strengthening the Social Safety Net. Funds for indigent health care could go to local health care agencies (LHCAs), which would be responsible for providing uncompensated health care. Those lacking private health insurance and not covered by a federal health insurance program would be self-insured for the amount of their personal assets. Once an individual's assets were depleted, the remaining costs would be paid by an LHCA — just as Medicaid currently assumes financial responsibility for private-pay patients who enter nursing homes. This safety net program and the refundable tax credits should replace Medicaid, as there would no longer be any purpose to be served by that program. These Medicaid funds would then be available to provide additional support for the safety net program, as well as help to finance the tax credits.

Source: John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

ing everyone at the same income level equally under the tax law. The government can also assure that tax subsidies go to those in greatest need and that those who choose not to purchase insurance pay higher taxes. Finally, the government can return the extra taxes paid by the voluntarily uninsured to local hospitals and clinics that deliver unreimbursed medical care. These extra taxes would fund the health safety net in the uninsured's own communities.

Should Preexisting Conditions Limitations Be Outlawed?

One problem with our health care system is that sick people who lose their health insurance sometimes find it impossible to purchase new coverage. Insurers may classify them as uninsurable, offer them a policy that excludes payment for medical services for their preexisting condition or set their risk-rated premium so high they cannot afford it.

The solution of the Clinton administration and many other reformers is to outlaw preexisting conditions limitations. Under the Clinton plan, no insurance company would be able to deny coverage or charge a higher premium to people who have expensive-to-treat illnesses. Under this type of regulation, called "guaranteed issue:"

- 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.

"If people can buy insurance after they get sick, they have an incentive to remain uninsured until they get sick."

To one degree or another, this reform is supported by many large health insurance companies and various trade associations and activist groups. The idea is incorporated in plans for small group health insurance reform by both Republicans and Democrats in Congress. Unfortunately, the idea is misguided.

How Big Is the Problem? According to the Agency for Health Care Policy and Research, a branch of the Public Health Service, only 0.7 percent of the U.S. population (about 2 million people) has been denied health insurance due to a medical condition. And while we do not know how many people must pay excessively high health insurance premiums, it could not be very many. Only about 3 percent of the population say they are in fair or poor health.[35]

Causing Premiums to Rise for Almost Everyone. Even though the problem is tiny, the solution considered here would affect almost everyone. And the effects would be quite large. Once preexisting conditions limitations were outlawed, sick people who are currently uninsured would buy insurance

in order to get their medical bills paid, and healthy people would let their policies lapse, secure in the knowledge that they could obtain coverage if they became ill. With more sick people and fewer healthier people in every insurance pool, premiums would have to rise. But as that happened, more healthy people would drop out — requiring even higher premiums.

How high premiums would eventually soar would depend on the specifics of the legislation, and every proposal is different. However, for small group health insurance reform (which does not include individual and family policies), here are some estimates of the likely increase in premiums:

- Milliman & Robertson, Inc. (an actuarial firm) estimates that a proposal for guaranteed issue insurance in New Hampshire would cause premium increases of 17.8 percent for individual policies and 10.2 percent for small groups, and cause from one-fifth to one-fourth of current policyholders to drop their coverage.[36]
- Community Mutual of Ohio (a Blue Cross/Blue Shield company) estimates that the Health Insurance Association of America small group reform plan would increase premiums by 20 to 25 percent.[37]
- Tillinghast estimates that a similar plan in the state of Ohio would increase premiums by 11 to 47 percent.[38]
- Golden Rule Insurance Company's actual experience was that guaranteed issue small group policies led to an increase in claims costs of over 50 percent in the second year and increases of 30 to 35 percent thereafter.[39]

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 those costs (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 insurers must accept people after they get sick, premiums for other people will soar."

- 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 family with $100,000 in annual income.
- Thus the tax rate on a family with a $10,000 annual income would be ten times as high as the rate for a $100,000-a-year family.

Increasing the Number of People Without Health Insurance. Contrary to widespread impressions, most of the 39 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under age 30 and in the healthiest population age group.[40] 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 the uninsured lack health coverage is that they have judged the price too high relative to the benefits. As noted above, very few have been denied coverage because of a preexisting medical condition.

Increasing the premiums charged to healthy people, therefore, will almost certainly increase the number who choose to be uninsured. For example, the National Center for Policy Analysis/Fiscal Associates Health Care Model predicts that, other things equal, a 10 percent increase in premiums will lead to a 6 percent reduction in the number of people who are insured.

The Politics of Preexisting Conditions. Health reform that ends up substantially increasing costs for the great majority in order to provide a benefit to less then 1 percent will exact a high political price. Such reform will rightly be seen as an effective tax increase. Angry voters will exact swift retribution on the supporters of such reform. They also will force its repeal, leaving nothing achieved. This is exactly what happened in the catastrophic health care legislation in the late 1980s. When a substantial portion of the elderly found they had to pay significantly higher taxes to finance expanded catastrophic coverage for other retirees, they rebelled en masse and forced repeal of the legislation.

Better Solutions. Instead of regulating the health insurance of 99 percent of the population, we can solve the problems of the 1 percent directly. In 28 states, high-risk pools now allow people who are uninsurable to buy affordable policies. Fully funding the existing risk pools and extending the idea to the remaining states would be a relatively inexpensive way of solving one social problem without creating others.[41] [See the sidebar on Better Solutions.]

"It's better to help directly the 1 percent of people who are uninsurable than to regulate the other 99 percent."

Further reforms would encourage people to become continuously insured, making risk pools unnecessary. For example:

- Medical Savings Accounts (MSAs) would give people a store of funds to make premium payments and continue insurance coverage while they are between jobs at which they receive employer-provided coverage. [See the discussion below.]
- Tax fairness would give tax relief to people who currently must buy their own insurance with aftertax dollars — the self-employed, the unemployed and employees of small business who do not receive employer-provided coverage. [See the sidebar on Universal Coverage.]

- Vouchers in the form of refundable tax credits would provide the poor with the funds to purchase essential health coverage.
- Guaranteed renewability would prohibit insurers from canceling people's policies or subjecting policyholders to sharp rate hikes if they got sick. [See the sidebar on Better Solutions.][42]
- Portability would assure that people would not lose their coverage when they switched jobs. [See the sidebar on Better Solutions]

Do We Need Community Rating?

"Community rating would increase premiums for young people by 50 percent."

Community rating requires insurers to charge everyone the same premium, regardless of expected costs. It is a natural extension of outlawing preexisting conditions limitations. While the latter regulation requires insurers to ignore the expected health costs of people with preexisting conditions, the former requires insurers to ignore expected costs for any individual by forcing them to treat all applicants the same.

To many people, community rating seems fair. But it creates enormous problems. It causes most people to be overcharged. It increases rather than reduces the number of uninsured. It causes a massive redistribution of income from poorer to wealthier families. And it subsidizes and encourages unhealthy lifestyles.

Higher Premiums for Most People. Community rating would benefit some and penalize others. Those who have above-average expected health care costs would gain, while those with below-average expected costs would lose. For example, one way in which expected costs differ is by age. In general, the expected health care costs of adults ages 60 to 64 are two to three times as high as the expected costs for those 25 to 29. In order to see what difference community rating would make, health economists David Bradford and Derrick Max analyzed the distribution of expected medical expenses and concluded that:[43]

- Although the average cost of health insurance (the community-rated premium) under the Clinton plan is predicted to be about $2,000 in 1994, the cost of health insurance is $1,350 for people ages 25 to 29 and $4,000 for people 60 to 64. [See Figure II.]
- Community rating under the Clinton plan would force health plans to overcharge young people by about $650 per year and subsidize older people by about $2,000.
- The Clinton plan would "tax" people ages 25 to 34 about $26 billion a year in order to help provide an annual subsidy of about $33 billion to those 55 to 64.

Better Solutions for Preexisting Conditions

Rather than regulate the insurance of the vast majority of people in order to give help to the few who have preexisting conditions, we should adopt reforms that encourage people to maintain continuous coverage — so the problem doesn't arise in the first place — and make risk pools available for those who fall through the cracks.

Personal and Portable Benefits. The federal tax law has encouraged an employer-based system under which people lose their health insurance when they leave a firm. Employers often can cut back coverage even after an employee gets sick. And when employees with a preexisting illness leave, they may find it impossible to obtain insurance coverage elsewhere. A much fairer system would be one under which no tax subsidy is available for employer-provided health insurance unless the policy is personal and portable. This reform would permit employers to take their health insurance with them during job transition. Companies that self-insure would have to contract with an insurer for this feature or continue to provide coverage themselves.

Medical Savings Accounts. Personal Medical Savings Accounts (MSAs) would also help people maintain continuous insurance coverage, especially during spells of unemployment. Half of the uninsured are uninsured for six months or less. In most cases, they are workers who are in job transition and have little savings to pay health insurance premiums while unemployed. MSAs would provide a source of funds to pay their health insurance premiums and continue coverage under their previous employer's plan, as provided under COBRA legislation, or to purchase an individual policy.

Tax Fairness. Federal tax law generally subsidizes employer-provided health insurance coverage by excluding premium payments from the employees' taxable income. No tax relief, however, is given to the self-employed, the unemployed and employees of small businesses that do not provide insurance. This makes the aftertax price of health insurance as much as twice as high, and encourages people to remain uninsured until they can get tax-subsidized insurance through an employer. Tax fairness requires that people receive the same tax relief, regardless of who buys the insurance. This would encourage people to maintain continuous coverage.

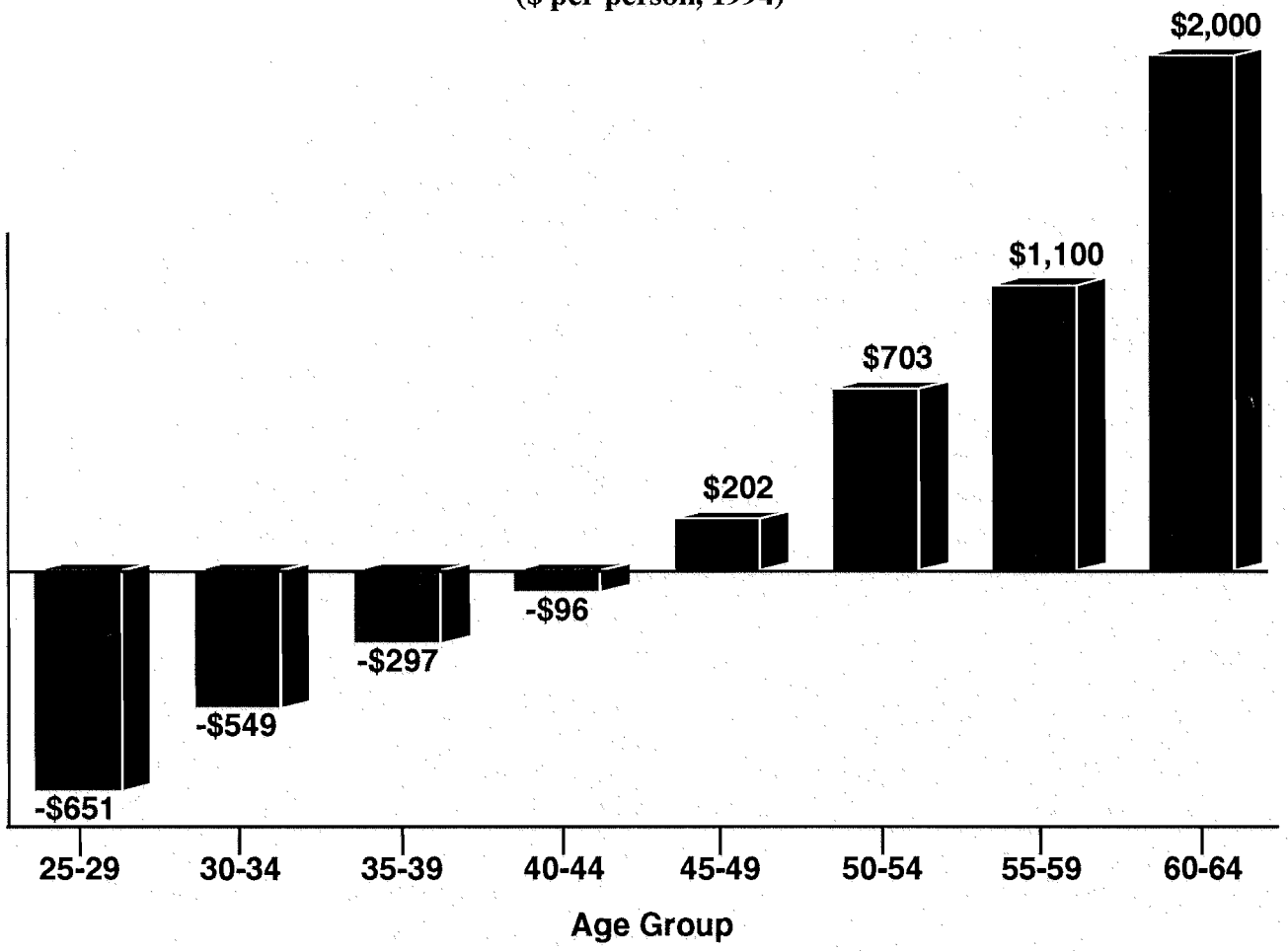
Guaranteed Renewable Insurance. Most of the problems in the market for private health insurance do not exist in the market for life insurance. In the latter, insurers cannot selectively raise prices for different policyholders based on last year's experience. The same premium increase must apply to the 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. These same rules should apply to health insurance as well. Once a person is insured, health insurers should be required to continue to offer coverage in the future at reasonable prices.

Risk Pools. Risk pools sell insurance to individuals who cannot obtain policies elsewhere, and 28 states now have them. Premiums are generally 25 to 50 percent higher than the prices of similar policies sold in the marketplace. But even at that, these policies are a bargain for people with high medical costs. Risk pool losses are covered either from general tax revenues or by "taxing" insurers, usually based on each insurer's share of the market. Properly established, high-risk pools could meet the needs of those who have been denied health insurance, leaving the market free to meet the needs of everyone else.

FIGURE II

Average Subsidy in Clinton Plan

($ per person, 1994)



Source: David A. Bradford and Derrick A. Max, "Soak-the-Young Economics of Clinton's Health Care Plan," American Enterprise Institute, 1994.

"Younger workers would be forced to subsidize the insurance of older workers who earn higher incomes."

Overall, workers below their mid-40s would generally pay more under community rating.[44] And the increases in premiums could be substantial:

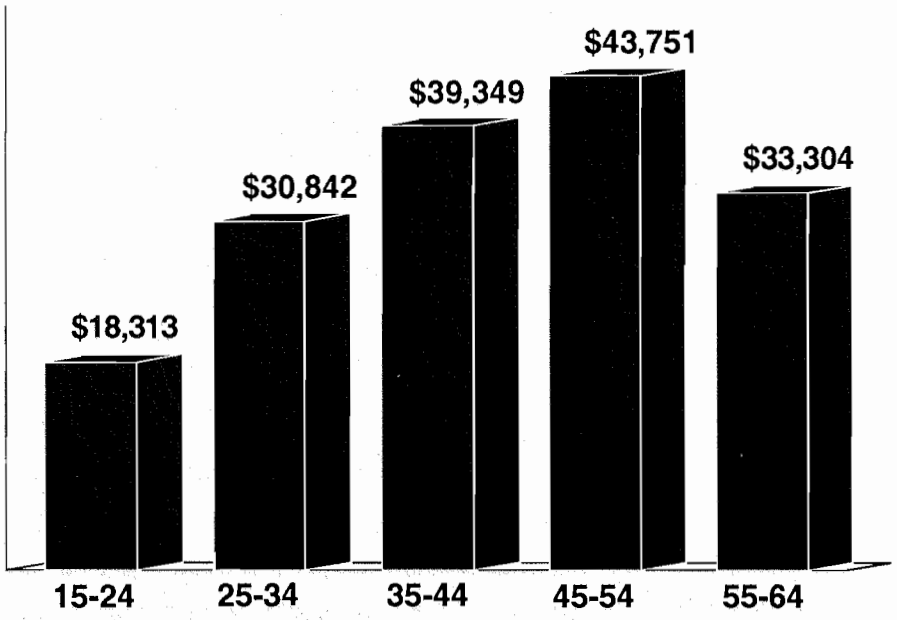
- In a recent article in the *Journal of American Health Policy*, three health insurance actuaries concluded that under community rating 37 percent of workers employed by small businesses would pay at least 10 percent more under community rating, and 20 percent of the workers would pay 20 percent more.[45]
- A study by the American Academy of Actuaries concluded that under community rating about 38 percent of the privately insured, nonelderly population would face premium increases of 6 percent or more and 20 percent would pay an additional 20 percent or more.[46]

"Income tends to rise with age."

FIGURE III

Median Income By Age of Householder

(1991)



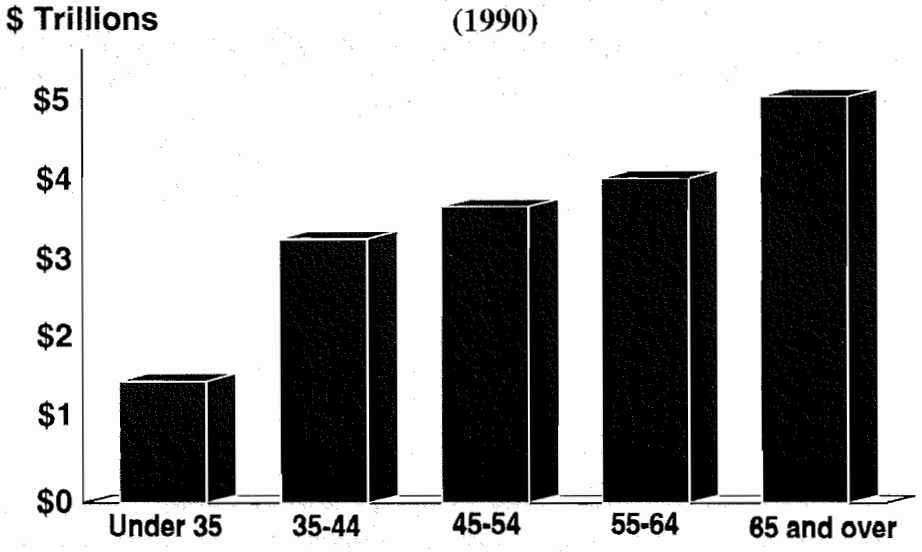
Source: Householder 1991 Current Population Survey (median income for householders). "Money Income of Households — Percent Distribution, by Income Level, for Selected Characteristics: 1991" in *Statistical Abstract of the United States*, 1993, p. 458 (Table No. 713).

"Young people have fewer assets than any other age group."

FIGURE IV

Distribution of Assets[1]

(1990)



[1] Assets exclude the present value of pensions and Social Security wealth.

Source: *Changing Times*, March 1990.

Redistribution of Income From Those Who Have Less to Those Who Have More. For the most part, those who would pay more under community rating are lower-income families, while those who would pay less have higher incomes. That is because younger workers, who would be forced to pay higher premiums, have far less income and far fewer assets than older workers, who would pay less.

- As Figure III shows, the median income of householders ages 35 to 44 is about one-third higher than for those 25 to 34 and more than double the income of those 15 to 24.
- The median income for people ages 45 to 54 is about 50 percent more than for those 25 to 34 and more than double the income of those ages 15 to 24.
- As Figure IV shows, those under 35 have substantially less than half the assets of those ages 45 to 64.

Increasing the Number of People Without Health Insurance. As noted above, people who are young and healthy and who have below-average incomes and few assets are especially sensitive to the cost of health insurance. These are the characteristics of most of the currently uninsured. And many more of them will become uninsured if they are forced to pay premiums that are 50 percent higher than at present. Premium reductions for older people are unlikely to swell the ranks of the insured by very much, but huge premium risks for younger people are likely to deplete those ranks significantly. Evidence from New York state supports this observation.

"After one year of community rating in New York, 43,666 people have canceled their insurance."

Case Study: Community Rating in New York. In 1993, the state of New York passed legislation requiring insurers to accept all applicants regardless of health status and to charge everyone the same premium for health insurance. According to the New York Department of Insurance:[47]

- In just the first year of community rating, almost 30 percent of the insured experienced premium increases ranging from 20 to 59 percent.
- Rates for a 30-year-old single male increased by 170 percent.

The intent of the New York law was to increase the number of insured by charging higher premiums to healthy people in order to subsidize the premiums of high-risk people. The result: as sick people entered the market, causing costs and premiums to rise, healthy people left. According to the New York Insurance Department, 43,666 individual policyholders have canceled their policies. Those moving out of the health insurance market are the younger, healthier segment of the population.[48]

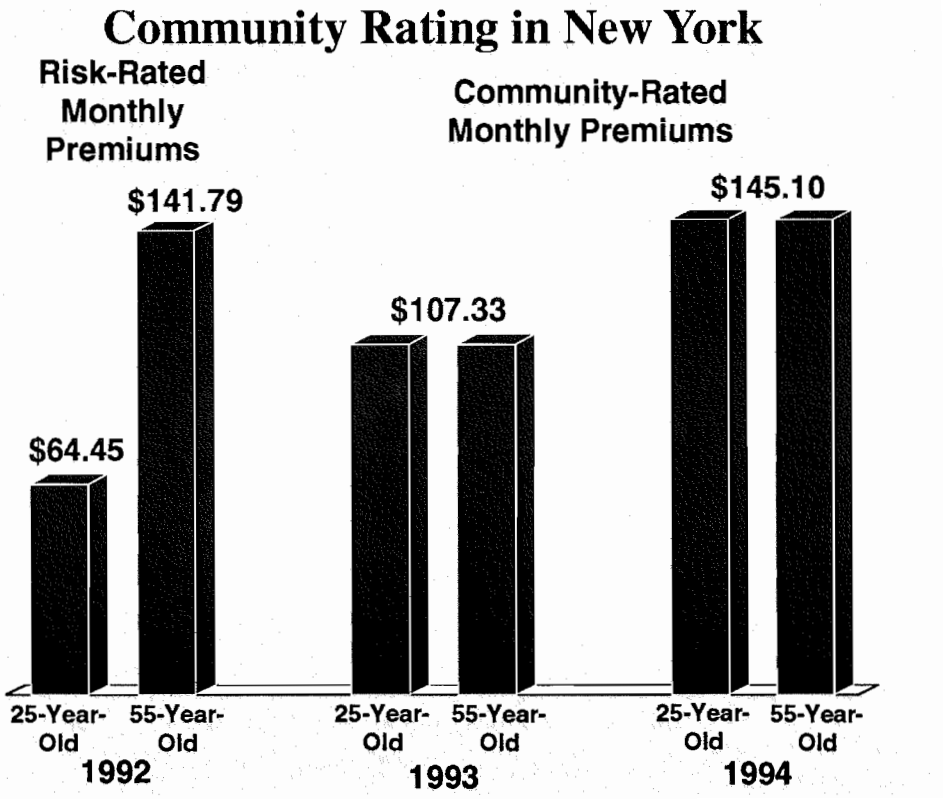
The New York experience suggests that community rating hurts those it is designed to help. Before community rating was instituted, Mutual of Omaha charged a 25-year-old male in Albany $64.45 a month for health insurance. A 55-year-old paid $141.79. After community rating, both paid $107.33, a 60 percent increase for the 25-year-old and a 32 percent decrease for the 55-year-old. Because of higher costs, however, this year both will pay $145.10 — more than the 55-year-old was paying *before* community rating was implemented. [See Figure V.] Thus, even those who are initially helped by the program are made worse off as cost increases push up premiums.[49]

Encouraging Unhealthy Lifestyles. When insurance premiums are determined in competitive markets, higher-risk individuals face higher premiums. This forces people who engage in risky behavior to bear the financial burden of that risk or to change their behavior. By contrast, community rating shifts most of the financial burden of some people's risky behavior to everyone else. This practice rewards risky behavior and penalizes healthy behavior. In other words, it would reward smoking, overeating, alcoholism, drug abuse and promiscuity of all kinds. It would penalize abstinence, healthy eating habits, exercise, monogamy, fidelity and marriage.

Modified Community Rating. Some proposals would impose modified community rating,[50] under which insurers could vary premiums for such factors as age and geographic location. Modifying community rating would

"In the second year, community rating in New York was hurting the very people it was designed to help."

FIGURE V



moderate the premium increases for younger and healthier people and limit the massive transfer of wealth from young to old. However, it still would be problematical. It would lead to higher premiums for healthy people and cause more people to be uninsured, and it would also lead to a lower quality of health care, as described in the following section.[51]

The Politics of Community Rating. Community rating is popular in Congress and has some appeal with voters who do not understand its negative consequences. Once they do, politicians will pay a heavy price for supporting this reform. Those who support community rating should recognize that it would raise the premiums of a very high proportion of their constituents.

Community rating also would undermine the values that many in Congress profess to support. People whose lifestyles reflect traditional family values tend to have substantially lower health costs than other people. This results from monogamy, avoidance of addictive substances and other factors. Yet because community rating prohibits insurers from considering the health status of applicants in setting rates, it forces those who adopt traditional and family values to pay substantially more so those who do not can pay less. Effectively, community rating taxes traditional and family values and subsidizes their antitheses.[52]

"Community rating penalizes people who adopt healthy lifestyles."

Alternatives to Community Rating. Many mistakenly believe that the only alternative to community rating is experience rating. Under that approach, insurers reevaluate the health status of their current policyholders each year and base premium increases on the expected health costs of each policyholder. Yet experience rating defeats the whole purpose of health insurance, since it does not protect the insured beneficiaries from high health costs after they become sick. For example, if a male policyholder gets cancer, he can expect premium increases for his own coverage to increase sharply at the end of the year to recover the costs of treating his cancer. Such "insurance" is worthless if not fraudulent.

Part of the solution to this problem is guaranteed renewability, which protects the insured from the costs of becoming sick and which prohibits insurers from cancelling a policy or raising premiums because a person becomes sick.[53] In addition, tax credits for low-income families would ensure that everyone could get guaranteed renewable insurance. For those who nevertheless did not buy insurance when they were healthy and became uninsurable, state risk pools would insure that they could get health insurance for a reasonable premium.

Should Managed Competition be the Model for Reform?

The Clinton plan would abolish the current system of health insurance and replace it with an artificial market in which insurers (or health plans) would be subject to considerable regulation. Like the reforms discussed above, the Clinton plan would:

- Require health plans to accept all applicants regardless of health status.
- Prohibit health plans from excluding coverage or charging a higher premium for preexisting conditions.
- Require all health plans to charge the same premium (community rating) to all applicants, regardless of their health.

But the Clinton plan would do much more than that. It would encourage people to periodically shop among plans — and encourage health plans to vigorously compete for customers — even after we know who is sick and who is well. Of course, the premiums of the sick would be well below the expected cost of their treatment, while the premiums of the healthy would be substantially higher. As a result, the incentives for plans to avoid the sick and attract the healthy would be far greater than under the current system. Indeed, the plans that attracted a disproportionate number of sick people would eventually fail and leave the market.

"Incentives for health plans to avoid the sick and attract the healthy would be far greater than under the current system."

According to the Congressional Budget Office, this scheme, called "managed competition," has never been implemented anywhere in the world — a fact that should give policymakers pause about imposing it on one-seventh of our economy.[54] President Clinton and other proponents of managed competition point to the Federal Employees Health Benefits Program (FEHBP) as the model for the reform they advocate.[55] But many health economists believe that FEHBP is only a distant cousin of the real thing; and in any event FEHBP is so flawed that it would be a poor model for national reform.[56]

Let's take a closer look at the problems managed competition would cause.

Perverse Incentives for Health Plans.[57] Under this system, people would have an incentive to shop for medical services when selecting a health plan. For example, heart patients would tend to choose the plan with the best cardiologists, while cancer patients would tend to choose the plan with the best oncologists. By contrast, healthy people would tend to choose plans with the best primary care services and amenities — secure in the knowledge that they could always switch plans if they became seriously ill.[58]

This would create perverse incentives for managers of health plans. For example, *no plan could afford to be known as the best for those with expensive-to-treat illnesses.* Such a reputation would attract sick people paying the community-rated premium and needing expensive medical treatment. Moreover, each health plan would have an incentive to underprovide services to the sickest people and overprovide services to the healthy. The reason is that the plan would become more profitable as the sick left and the healthy stayed.

The quality of care delivered to the sick would probably not deteriorate immediately. Nor would all diseases be affected in the same way. Health policy analysts believe that the patients at greatest risk initially would be those with chronic conditions — patients in need of mental health care, custodial care or long-term care. Where physicians have discretion, as in treating leukemia or saving premature babies, the tendency would be to save money rather than prolong life. There would be a substantial decrease in the number of CAT and MRI scans and other costly tests that detect brain tumors, cancer and other life-threatening conditions. Where possible, expensive surgery (such as bypass operations) would be delayed — if for no other reason than the plan administrators' hope that the patient might switch health plans and have the surgery performed by a competitor.

"No plan could afford to be known as the best for those with expensive-to-treat illnesses."

Result of Managed Competition: An Absence of Fee-for-Service Plans. Some might suppose that they can avoid low-quality medicine by choosing a fee-for-service plan. By the nature of fee-for-service plans, patients are free to select a physician and physicians are free to practice medicine according to their conscience and their knowledge of medical procedures. These freedoms would make it virtually impossible for fee-for-service plans to avoid the sick if they were in competition with HMOs. Since they are likely to be attractive to sick people whose premiums are well below the cost of their medical care, these plans are unlikely to survive. Proponents of managed competition are well aware of this. Jim Cooper, for example, says, "My guess is that fee-for-service medicine will be discouraged and mostly die out."

Result of Managed Competition: Lower-Quality Care for the Sick. A number of health economists are convinced that the end result of competition under the Clinton plan would be a market in which each person received medical care costing exactly the same as the community-rated premium that person paid. Specifically:

- The tendency of managed competition would be to compete the amount health plans spent for the care of the sick down to the level of the premiums the sick paid.
- By contrast, there would be a natural tendency to compete the amount health plans spent on the healthy up to the level of the premiums the healthy paid.
- As a result, seriously ill people would be progressively denied access to the benefits of modern medical science, while healthy people would have access to services that are medically unnecessary and only tangential to health care.

These conclusions follow from well-known principles of the economics of regulation. In competitive markets, price tends to change until it equals average cost. But if prices are constrained, competition will cause cost to change until it equals price, primarily through changes in quality. For example, when housing rents are kept artificially low by rent control, landlords tend to allow housing quality to deteriorate until housing costs fall to the level of the government-controlled rents. When airfares were kept artificially high under airline regulation, the airlines tended to increase quality by adding more flights and amenities until their costs rose to the level of the government-controlled fares.[59]

"Ultimately, health plans could afford to spend no more on a patient than the amount of premiums the person paid."

Do We Need Regional Alliances?

As part of its general managed competition scheme, the Clinton plan relies on mandatory regional alliances. Each state would set up one regional alliance for each geographic area. Everyone would be forced to select among the insurance plans offered by a regional alliance. If managed competition has any hope of working, mandatory regional alliances are probably necessary. But for those who reject managed competition, there is no particular reason why federal health care reform needs to involve alliances. However, if it does, three principles should be followed.

Principle of Reform: Regional alliances must be voluntary, not mandatory. Mandatory regional alliances restrict consumer freedom of choice because they force consumers to buy insurance from the limited set of plans their alliance offers rather than from all the plans in the marketplace. They also force consumers to buy their insurance through a single intermediary, rather than directly or from any intermediary they may choose.

Mandatory regional alliances also restrict competition. They involve a classic government-imposed barrier to entry, since insurers not included in the regional alliance are not free to compete for customers in the alliance's region. This increases the market power of the insurers that are allowed to compete,

"Mandatory alliances restrict competition and outlaw consumer choice."

enabling them to charge higher prices, provide lower-quality service and reap above-market returns. Clinton's regional alliances are intended to grant consumers the market power of a group purchasing pool. But if the number of insurers in each regional alliance is limited enough, the alliances would effectively be insurance cartels with the power to dominate consumers.

Finally, mandatory regional alliances would leave consumers at the mercy of the alliance bureaucracy. They would have no incentive to provide good quality service to consumers. Consumers would not be allowed to seek better service elsewhere. And the alliance would inevitably favor the interests of its bureaucrats over those of its consumers.

These problems can be avoided by making the alliances voluntary. Consumers would then be free to choose them or any other insurance option in the market. Competition would not be limited only to those insurers allowed in the regional alliance. Alliances would have to compete to attract consumers and would therefore have incentives to provide high-quality service. If they failed to do so, consumers would be free to choose other alternatives.

Making the alliances voluntary is essential to ensuring that they benefit consumers. They would prosper and grow to the extent they did so. If they did not, they would wither and die, and properly so.

Principle of Reform: Regional alliances must be competitive, not monopolistic. Regional alliances should not be limited to one for each geographic area, and consumers should not be required to choose an alliance in one geographic area. Such restrictions on consumer choice would eliminate competition among alliances. Consumers would be better served by competition among any and all alliances that may be formed and by choice among alliances nationwide.

Principle of Reform: Regional alliances must be established by the private sector, not by state governments. Any group of private individuals or employers should be free to establish a health insurance purchasing cooperative or alliance anywhere. This is essential to ensuring competition and choice. A state-established alliance would tend to be state-dominated and controlled. Over time, it would likely grow into a state bureaucracy demanding more power and control over health care and special preferences over other alliances. Consequently, state and federal governments should leave the establishment of regional alliances to the private sector. If such alliances perform a useful function, employers, individuals and others in the private sector will form them.

Under these principles, employers, workers and patients would be able to benefit from any efficiencies regional alliances might offer, while retaining freedom of choice.

Do We Need Global Budgets and Price Controls?

Although the Clinton administration refuses to acknowledge the terms "global budgets" and "price controls," its plan includes both. Bureaucrats at the National Health Board in Washington would determine how much the entire nation could spend on health care each year. They would then enforce this global budget through controls on the premiums each health plan charged, and on the fees that fee-for-service doctors and hospitals charged.[60]

"If the Clinton spending targets were met, one out of every six procedures would have to be rationed by the year 2005."

Why Controls Would Cause Rationing. Global budgets and price controls would force physicians and hospital personnel to ration and deny health care in order to reduce costs. Through this system, the resources available to health plans and the amount that could be spent on health care would be severely restricted. For example, the Clinton plan sets targets that would limit the growth of health care spending to the growth in the Consumer Price Index (CPI) by 1999.[61] Not even Canada has successfully controlled spending to this degree, and most health economists do not take the targets seriously. However, according to one study:[62]

- If the Clinton plan spending targets were met (say, due to the imposition of strict global budgets), about 18 percent of health care services would have to be rationed by the year 2005.
- In other words, almost one out of every six health care services would have to be rationed at the end of just one decade.

This would result in severe and arbitrary cutbacks in the services and quality of care provided by doctors and hospitals. They would no longer be able to acquire and offer the latest innovations, newest technologies and most cutting-edge treatments. Patients would be subject to delays and long waiting lines for diagnostic tests, surgery and other health care, since the system would no longer have the resources to provide prompt and ready care.[63]

"Under Canada's global budgets, 1,379,000 people are waiting for some medical service."

Case Study: Canada. As an example of how global budgets would work, consider Canada's health care system. The Canadian system strictly limits the amounts that doctors and hospitals can spend on health care and forces them to ration services as a result.[64] Currently, about 1,379,000 Canadians (out of a total population of 26 million) are waiting for some medical service, ranging from visits to general practitioners to nursing home admissions. Of those, more than 177,000 people are waiting for surgical procedures. They must endure lengthy waits before they can meet with a specialist and even longer waits before they can get needed surgery. For example:[65]

- The average wait to see an eye specialist in Prince Edward Island is six months — and it takes another six months on the average to be treated.
- On the average, it takes almost seven weeks to see a gynecologist in New Brunswick and another six months to be treated.
- To see an ear, nose and throat specialist takes a little more than two weeks in Newfoundland — but it takes another six months to be treated.

According to Statistics Canada, 45 percent of those waiting describe themselves as "in pain," and the Canadian press is full of examples of patients who have died because their heart surgery was delayed.[66]

And despite the claim that in Canada everyone has a right to health care, Canadians have no enforceable right to any particular medical service. They don't even have a right to a place in the rationing line. For example, the 100th person waiting for heart surgery is not entitled to the 100th surgery. Other patients can and do jump the queue for any number of reasons. Until adverse publicity put a stop to it, even animals could jump the queue and get a CAT scan at York Central Hospital in a Toronto suburb. The tests were done at night and the charge was $300 each. But people are not allowed to pay for a CAT scan.[67]

"Americans have more rights in the Canadian health care system than Canadians do."

Americans would ultimately be subject to the same delays, waiting periods and loss of access to expensive technology that Canadians are. These global budgets would be a central planning approach to controlling costs, totally inconsistent with free markets in health care. Federal government bureaucrats have no way of knowing how much the nation should spend on health care, and their global budget limits would be wholly arbitrary. Moreover, such heavy government control is inherently authoritarian and oppressive. It is inconsistent with the essential freedom of the people to control one of the most fundamental, intimate aspects of their lives — their own health care.

Do We Need Medical Savings Accounts?

The root cause of rapidly rising health costs is third-party payment of medical bills. In health care, someone other than the consumer is usually paying the bills — whether that someone is an employer, insurance company or the government through Medicare and Medicaid. As a result, consumers have weak incentives to avoid unnecessary or overly expensive care. Moreover, since they seldom pay for services themselves, they choose doctors and hospitals almost entirely on the basis of quality rather than cost. For that reason, doctors and hospitals compete almost exclusively to maximize quality rather than to reduce costs.

"With Medical Savings Accounts, people would control their own health care dollars."

How Medical Savings Accounts Work. Medical Savings Accounts (MSAs) are designed to correct this problem.[68] Instead of using all their health care dollars for third-party health insurance, employers and their employees could choose third-party catastrophic insurance with a high deductible, say $3,000 per year. They could then put the remainder of what would otherwise have been premium expense into a tax-free Medical Savings Account for each employee. The employee could then pay for health expenses below the deductible with funds from the MSA. Ideally, the employee could withdraw any remaining MSA funds for any purpose at the end of the year — subject only to normal income taxation — and roll over any unspent MSA funds into an IRA or other tax-deferred savings fund at the time of retirement.

Individuals and families would pay routine health expenses out of their own MSA funds. This would give patients strong incentives to control costs. Perhaps more importantly, doctors and hospitals would compete to reduce costs as well as maximize quality. They would seek to please consumers by advising them on how to lower costs while maintaining quality.

Medical Savings Accounts in the Private Sector. The MSA concept has been implemented at Golden Rule Insurance Company in Indianapolis with great success. Employees are offered a traditional insurance policy with a $500 deductible and a 20 percent co-payment up to a maximum of $1,000. Or they can choose an MSA. In that case, the employer deposits $2,000 into an MSA in 12 equal installments over the year and provides the employee with complete catastrophic coverage above a deductible of $3,000. Each employee's maximum out of-pocket expense is $1,000.[69]

In 1993, 80 percent of Golden Rule employees chose the MSAs. At year-end, they were able to withdraw the remaining funds in their accounts — an average of $602 per employee — and health costs for the company were reduced by 40 percent. In 1994, 90 percent of the employees chose MSAs.

Other companies have tried similar approaches and also have had impressive results:[70]

- Dominion Resources, a utility holding company, deposits $1,620 a year into a bank account for the 80 percent of employees who choose a $3,000 deductible rather than a lower deductible. As a result, the company has experienced no premium increases since 1989, while other employers have faced annual increases averaging 13 percent.
- *Forbes* magazine pays each employee $2 for every $1 of medical claims they do not incur up to a maximum of $1,000. As a result, *Forbes'* health costs fell 17 percent in 1992 and 12 percent in 1993.

- Beginning in 1982, Quaker Oats implemented a high-deductible policy and paid an annual $300 into the personal health accounts of employees, who get to keep any remaining balance. Although the IRS recently forced the company to abandon this plan, it was highly successful; over the past decade the company's health costs grew an average 6.3 percent per year, while premiums for the rest of the nation grew at double digit rates.

The United Mine Workers recently adopted a similar approach for their workers. Last year they had a health plan with first-dollar coverage for most medical services. This year they accepted a plan with a $1,000 deductible. In return, each employee receives a $1,000 bonus at the beginning of the year, and employees get to keep whatever they don't spend.

"Employees get to keep the money they don't spend."

The Need for a Change in the Tax Law. Under current law, unspent Medical Savings Account balances are taxable, but health insurance premiums paid by an employer are not. Thus the tax law subsidizes third-party insurance and penalizes individual self-insurance. In this way, the tax law subsidizes the problem and penalizes the solution. Wise tax policy would give just as much encouragement to self-insurance through Medical Savings Accounts as to third-party insurance.

Does Health Reform Require Tax Reform?

Because federal tax law states the conditions under which health insurance and health care expenditures qualify for generous tax subsidies, in a very real sense the tax law has shaped and molded our health care system. As a result, fundamental reform of our health care system is impossible without changing the tax law.

We just discussed how the tax law needs to be changed to put individual self-insurance through Medical Savings Accounts on a level playing field with third-party insurance. Other changes are also needed.

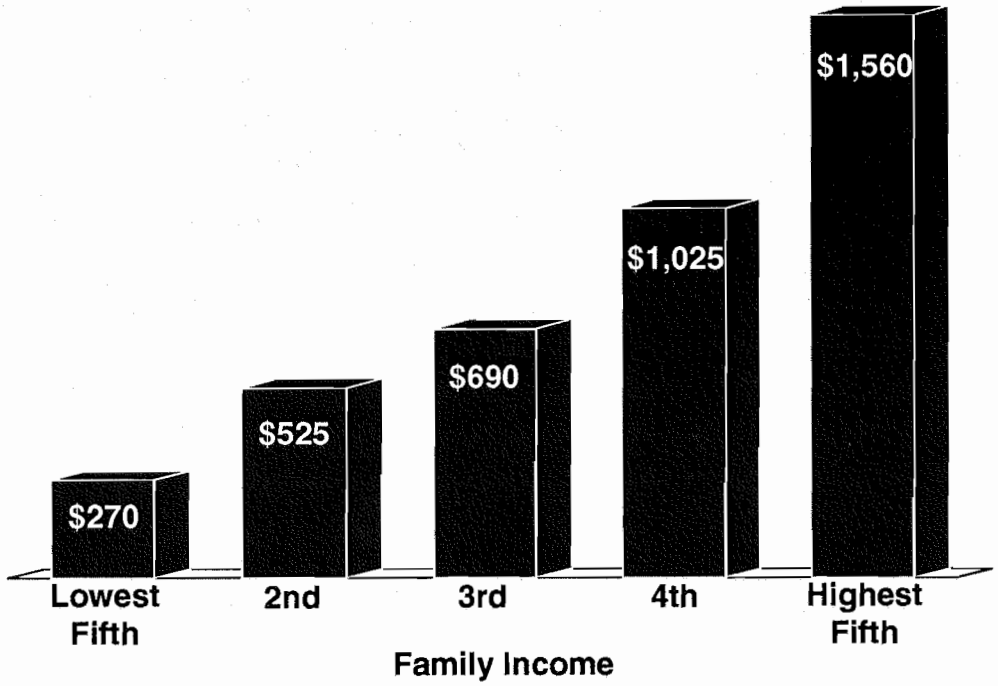
Tax Fairness: Equal Treatment of Equals. The federal government currently "spends" about $86 billion a year in tax subsidies for health insurance, and state and local governments spend another $10 billion. These subsidies exist because employer-provided health insurance is excluded from employees' taxable income.

At the same time, the self-employed, the unemployed and employees of small companies that do not provide health insurance are discriminated against. They must pay taxes first and buy health insurance with what's left over. This can make their health insurance cost twice as much as it would if provided by an employer.

"Most of the subsidies go to the highest-income families."

FIGURE VI

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



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

Source: C. Eugene Steuerle, American Enterprise Institute.

A fair tax system, by contrast, would give the same tax break to all individuals with the same income, regardless of where the insurance is purchased.

Tax Fairness: More Help for Lower-Income Families. As Figure VI shows, current tax subsidies favor high-income over low-income families:

- Families in the bottom fifth of the income distribution get an average benefit of $270 a year from federal tax subsidies for health insurance.
- Families in the highest fifth of the income distribution get an average benefit of $1,560.
- Thus the tax law benefits high-income families six times more than it benefits low-income families.

A better approach is to offer everyone a tax credit for the purchase of health insurance, with higher credits for lower-income families. For individual purchases of health insurance, a tax credit can be entered on individual income tax returns. The cost of employer-provided insurance can be included in the gross wages of employees and tax credits entered on their tax returns. For those with very low incomes, there can be refundable tax credits — with government providing most of the funds for their health insurance premium through a system of vouchers.

Tax Penalties for the Uninsured. The flip side of a tax subsidy is a tax penalty. If government offered tax subsidies to people conditional on their purchase of health insurance, those who choose not to purchase insurance would pay higher taxes. The higher taxes might be thought of as a penalty for being uninsured.

"Through refundable tax credits, every family could afford to purchase health insurance."

For example, suppose that the average family is entitled to a 33 percent credit against the first $4,500 of health insurance. This means that if the family purchases insurance, they can reduce their tax liability by up to $1,500. Families that are uninsured will not receive this tax relief. Thus, compared to families that are insured, families that are uninsured will pay up to $1,500 more in taxes each year.

Even under the current system, people who are uninsured pay a penalty because they do not receive the tax benefits available to those who have employer-provided insurance. Moreover, the extra taxes they pay may equal or exceed the amount of free care uninsured people receive from hospitals each year. Far from the standard rhetoric, therefore, the uninsured as a group are not getting a free lunch. Collectively they pay their own way, or most of it.

Establishing a Social Safety Net. As noted above, the way to create universal coverage without mandates is to return the extra taxes paid by the voluntarily uninsured to local hospitals and clinics that deliver unreimbursed medical care. These extra taxes would fund the health safety net in the communities in which the uninsured live.

This safety net program and the higher and refundable tax credits for low-income families should replace Medicaid, and there would no longer be a need for that program. Current Medicaid funds could then also be used to finance the tax credits and the safety net program.

Do We Need A Separate Insurance Plan for the Poor?

Assistance should be provided to those who cannot pay for basic health insurance on their own. This is necessary to ensure that no one will forgo insurance because of a lack of funds. To accomplish this, vouchers should be provided to the poor in the form of a refundable tax credit. These credits should be sufficient to enable the poor to buy essential coverage. But the poor should be free to use the credits to choose their own policies rather than be forced to purchase the package chosen by the government, and they should be able to use these tax credits for MSA contributions as well as the purchase of third-party insurance.

The amount of the credits should be reduced and eventually phased out as income rises. This assistance should replace Medicaid, and be financed with the funds from that program. Providing this assistance through tax credits would make the assistance automatic and would avoid bureaucratic interference and control. It would also mean that low-income families would participate in the same health system as everyone else, supported by progressive tax relief.

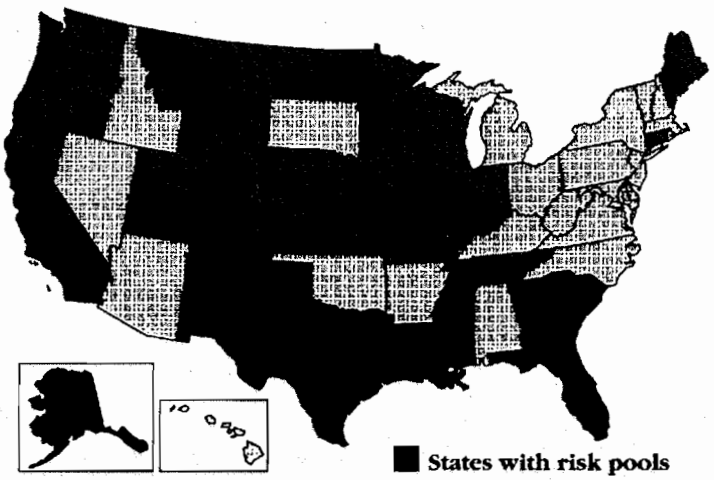
Do We Need Risk Pools?[71]

As noted above, one problem with our health care system is that many sick people who lose their health insurance find it impossible to purchase new coverage. To solve this problem, a number of states make subsidized insurance available through high-risk pools to people who can't purchase conventional coverage at a reasonable price. These states are directly solving the problems of the unfortunate few without imposing costly regulations on everyone else.

"Uninsurable people get insurance through risk pools in 28 states."

Solving the Problem With High-Risk Pools. Currently, 28 states have passed legislation creating high-risk pools that sell health insurance to approximately 100,000 individuals with preexisting conditions. [See Figure VII.] However, few people stay in risk pools for long, and the annual turnover rate of the pools is between 30 and 60 percent. People leave risk pools and obtain other health insurance in a variety of ways. For example, some turn 65 and qualify for Medicare; some get married and become insured under a spouse's policy; some resolve their medical conditions and qualify for standard insurance again; and some change jobs and are insured by a new employer.

FIGURE VII



How Do High-Risk Pools Work? In most states, the premium for risk pool insurance is between 25 and 50 percent higher than for comparable policies a healthy person can buy. However, some states require people to pay more if the program's losses warrant it. For example, Florida's risk pool premiums are two and a half times as high as the state's standard premium. And while Montana is legally permitted to charge as much as 400 percent above the standard premium, currently no one pays more than 250 percent. In Minnesota, one of the most generous states, risk pool insurance is less than 25 percent more expensive.

Most risk pool insurance provides benefits comparable to those offered by traditional health insurance policies within the state. Major insurers such as Blue Cross usually manage and underwrite the risk pool. Almost all pools offer fee-for-service insurance, rather than managed care or HMO plans.

To join a risk pool in most states, individuals must prove that they have been rejected by at least one of the state's insurers. Moreover, to discourage people from waiting until they are sick to get insurance, most of the pools can impose a preexisting condition exclusion period.

How Are High-Risk Pools Funded? Risk pools are funded largely by the people participating in the pool. However, even with higher premiums the pools usually lose money because their members are high health care users. States make up these shortfalls in different ways. In Maine, losses are covered by a tax on hospital revenues. In Illinois and California, the subsidies are funded by general tax revenues. In most states, insurers make up the deficit by paying assessments in proportion to their share of the market. In several of the states that assess insurers, companies are allowed to subtract most or all of their assessments from the premium taxes they pay to the state. To the extent that this occurs, the burden falls on general taxpayers.

"The best way to fund the losses of risk pools is through general taxes."

Case Study: Nebraska. Nebraska instituted its risk pool, the Comprehensive Health Insurance Pool, in 1985. Any resident who has been denied health insurance within the last six months can join the program for 135 percent of the cost of a standard major medical policy (based on the average cost of the state's five most popular plans). Currently:

- There are 3,309 people in the state's risk pool, about 0.2 percent of the state's population.
- A family of four can join the pool for about $400 a month.
- Partly because of other reforms implemented by the state, a family risk-pool policy in Omaha costs about the same as or less than a standard health insurance policy in many other cities — $532 per month in Miami, $403 in Dallas and $376 in Boston.

Individuals who have lost their insurance and cannot obtain coverage elsewhere can join the pool and be covered immediately. To stop people from signing up for the pool only when they get sick, the state imposes a pre-coverage waiting period of six months on those who have let their insurance lapse or were not previously covered.

"Extending risk pools nationwide would cost less than one-tenth of 1 percent of the nation's annual health bill."

Making Risk Pools Work Better. The biggest problem with risk pools is that they are sometimes underfunded. Texas, an extreme case, has had a risk pool on the books since 1989 but has never approved funding. At least one state excludes from coverage certain medical conditions. And some states exclude people who have reached the plan's lifetime benefit. Yet the amount of money needed to fully fund state risk pools is almost trivial in the context of a $1 trillion health care system. In 1992, for example, risk pool subsidies nationwide totaled only $170 million.

Other changes are also needed. While increases may be small, the practice of subsidizing risk pools with a tax on other premiums drives up the cost of insurance for healthy people and could encourage them to become uninsured. Similarly, subsidizing risk pools with a tax on hospital revenues imposes a tax on the general public only to the degree they get sick. A better solution would be to follow the example of California, Illinois and Utah — fund risk pool subsidies from general revenues and keep hospital fees and other health insurance premiums as low as possible.

Extending Risk Pools Nationwide. One study found that extending risk pool insurance nationwide would have cost only $300 million in 1989, out of a national health care bill of $604 billion that year. The study concluded that with aggressive cost control techniques, that number could be significantly reduced. But even without cost control, the cost of solving the problems of risk pool insurance would be less than one-tenth of 1 percent of the nation's annual health care bill.

Solutions for the uninsurable do not require that we destroy the health insurance market. Properly established, high-risk pools can meet the needs of those who have been denied health insurance, while the free market works for everyone else.

Conclusion: Competing Visions for Health Reform

Relatively simple reforms would go a long way toward solving our most pressing health care problems without creating new ones. Unfortunately, the underlying debate is not about how to solve our health care problems. It is about how our health care system should be organized.

"Under the Clinton plan, doctors would have to practice 'cookbook' medicine."

Bureaucratic Vision. Under the Clinton plan and most other proposals now on Capitol Hill, bureaucracies rather than individuals would make the most important decisions. People would be forced to join HMOs, whose doctors would serve as agents of the HMOs rather than of their patients. Administrative interference in the doctor-patient relationship would be routine; doctors would be encouraged to practice "cookbook" medicine, compelled to follow bureaucratic guidelines and pressured to avoid diagnostic tests, reduce hospital admissions and in other ways deliver lower-quality care.

President Clinton's proposed price controls and global budgets would make things worse by forcing HMOs to ration care. And bureaucrats would decide everyone's place in the waiting lines.

Patient Power Vision. The alternative to empowering bureaucracies is empowering individuals. People should be free to join HMOs if they wish. They also should be free to control most of their own health care dollars, using insurance to pay rare, catastrophic expenses. Since most physicians' fees would be paid from personal Medical Savings Accounts (MSAs), doctors would become financial as well as health agents of their patients, helping them make wise decisions in a complex medical marketplace. The doctor-patient relationship would be based on the welfare of the patient, not on the financial self-interest of an HMO.

"Patient-power reforms would make doctors agents of patients instead of agents of bureaucracies."

Patient Power Reforms. In order to empower patients and unleash the problem-solving capabilities of competitive markets, a sound package of health care reforms would have the following components;

- **Medical Savings Accounts**: Allow individuals to control most of their health care dollars through personal accounts and to rely on third-party insurance for rare, catastrophic expenses. Individually owned accounts would permit people to purchase cheaper, high-deductible health insurance and to put the premium savings into a tax-free account to use for smaller health care expenditures.
- **Individual insurance tax credits deductibility:** Allow individuals a tax credit for insurance they purchase directly or through non-employer groups, providing the same tax relief as for those who receive their insurance from employers.
- **Guaranteed renewability:** Prohibit insurers from canceling the coverage of or charging higher premiums to policyholders who have become sick.
- **Portability:** Allow workers to take their insurance with them when they switch jobs or to enroll in similar plans without facing premium increases due to health status.

- **Health insurance vouchers:** Provide refundable tax credits to all low-income people, including those currently on Medicaid, to pay for essential health insurance coverage.
- **State risk pools:** Guarantee insurance coverage at subsidized rates to those who get sick and become uninsurable.
- **Means-tested health care assistance**: Pay essential medical expenses the voluntarily uninsured cannot pay themselves by establishing a safety net, funding it with the higher income tax payments the uninsured would make.
- **Private sector, competitive, voluntary alliances:** Allow any group of individuals or employers to set up a health care purchasing cooperative (an alliance) for any region they choose, in competition with any other alliance, leaving consumers free to choose or reject any or all alliances.

Pro-Bureaucracy Reforms to Avoid. Legislators should avoid the following bureaucratic reforms:

- Employer or individual mandates.
- A government-defined standard benefits package of any sort.
- Community rating of any sort.
- Global budgets and price controls of any sort.
- Mandatory alliances or state-established regional alliances of any sort.
- A National Health Board to make decisions concerning the nation's health care system.

Benefits of Patient Power Reform. The pro-patient package of health care reforms discussed here is *the only effective tool for controlling costs* by providing individuals with economic incentives to avoid unnecessary spending and stimulating cost-cutting competition among health providers. It also *ensures that everyone, including the currently uninsured, can obtain essential medical care and insurance*, through a well-designed safety net for the poor and uninsurable.

"Only through patient power reforms can we control costs and avoid rationing."

Rather than invest more power and control over the nation's health care system in government and insurance company bureaucracies, as the Clinton plan does, patient power reforms would return that power and control to individuals and the doctors they select.

Peter J. Ferrara

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] For a thorough discussion of the case against the Clinton plan, see Peter J. Ferrara et al., "The Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 184, May 1994.

[2] Estimate based on data obtained from the Health Care Financing Admministration, the Employee Benefit Research Institute and Milliman & Robertson, Inc.

[3] Estimate made by Milliman & Robertson.

[4] Martin Feldstein, "The Impact of Health Care Reform on the Budget Deficit," address at the American Enterprise Institute Conference on Health Care Reform, September 23, 1993.

[5] June E. O'Neill and Dave M. O'Neill, *The Impact of a Health Insurance Mandate on Labor Costs and Employment: Empirical Evidence* (Washington, DC: Employment Policies Institute, September 1993).

[6] Richard Vedder and Lowell Gallaway, *Concealed Costs: The Real Impact of the Administration's Health Care Plan on the Economy* (Washington, DC: American Legislative Exchange Council, 1994).

[7] DRI/McGraw Hill, "The Administration's Health Care Reform Plan: National Macroeconomic Effects," February 1994.

[8] Morgan O. Reynolds and Lawrence A. Hunter, "A Billion Dollars a Day: The Financing Shortfall in President Clinton's Health Care Proposal," Joint Economic Committee staff, U.S. Congress, Washington, DC, January 1994.

[9] Gary Robbins and Aldona Robbins, "Forecasting the Effects of the Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 185, May 1994.

[10] See Ferrara, "The Clinton Health Plan."

[11] Laura Tyson, Chair, President's Council of Economic Advisors, quoted in the *Wall Street Journal*, October 7, 1993.

[12] Alan Krueger, "Observations on Employment-Based Government Mandates with Particular Reference to Health Insurance," paper presented at the Milken Institute for Jobs and Capital Formation Conference on Labor Economics, Employment Policy and Job Creation, Washington, DC, November 1993.

[13] Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (Washington, DC: U.S. Government Printing Office, 1994), p. 60.

[14] Clinton proposes a range of caps on required employer payments, with lower caps for smaller businesses. See Ferrara, "The Clinton Health Plan," p. 28. These caps would reduce the job loss to 780,000 at the start. But since the thresholds for the lower caps below the maximum of 7.9 percent are not indexed to inflation, over time these lower caps would be effectively phased out. With only the 7.9 percent employer payment cap remaining effective, about 900,000 workers would lose their jobs. June E. O'Neill and Dave M. O'Neill, *The Employment and Distribution Effects of Mandated Benefits* (Washington, DC: American Enterprise Institute, 1994).

[15] Vedder and Gallaway, *Concealed Costs.*

[16] Hunter and Reynolds, "A Billion Dollars a Day."

[17] DRI/McGraw Hill, "The Administration's Health Care Reform Plan."

[18] CONSAD Research Corporation, "Employment and Related Economic Effects of Health Care Reform," NFIB Foundation and the Health Equity Action League, April 1994.

[19] June E. O'Neill and Dave M. O'Neill, "Effect of the Employer Mandate in the Clinton Health Plan," Employment Policies Institute, March 1994.

[20] Aside from subsidies for small businesses that employ low-wage workers and a 7.9 percent cap on total employer premiums, the Clinton plan makes no distinction between high-wage and low-wage workers.

[21] Both the Chafee-Thomas bill and the original Nickles-Stearns bill, for example, combine an individual mandate with tax relief that diminishes as family income rises.

[22] "McLaughlin Report," June 26, 1994.

[23] "Larry King Live," May 4, 1994.

[24] It is possible to have a mandate without a government-defined benefits package. For example, Singapore requires all of its citizens to deposit 6 percent of their income in a Medisave account but does not require them to use the funds to purchase a health insurance policy. It is also possible to have a government-defined benefits package without a mandate. For example, the Cooper-Breaux bill specifies what type of insurance benefits people must have in order to qualify for tax relief, but does not require anyone to purchase the coverage.

[25] Even coverage for necessary services may not be desirable because it makes insurance premiums more expensive. For example, the cost of a diagnostic test is not reduced by insurance coverage. Rather, it is increased. Instead of paying the doctor directly, people with insurance coverage pay the cost through their premiums. Insurers must then pay the doctors. Adding a middleman only makes the total cost higher.

[26] Perverse incentives are created when a third party such as an employer, insurance company or the government pays medical bills. The practice removes consumer incentives to avoid unnecessary or overly expensive care and, by extension, physician and hospital incentives to reduce costs through vigorous competition. The result is rapidly rising health care spending coupled with inefficient delivery of health services. For further discussion, see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

[27] "1,081 State-Mandated Benefits Identified," *Health Benefits Letter*, Vol. 2, No. 2, July 31, 1992.

[28] Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits," *Inquiry*, Vol. 26, No. 4, Winter 1989.

[29] 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.

[30] Insurance Information Institute, "Compulsory Auto Insurance," *Insurance Issues Update,* January 1993.

[31] See, for example, Pamela Loprest and Michael Gates, *State-Level Data Book on Health Care Access and Financing* (Washington, DC: Urban Institute, 1993).

[32] British Columbia Ministry of Health, Health Information Line.

[33] Katherine Swartz, "Counting Uninsured Americans," Kaiser Health Reform Project, Henry J. Kaiser Family Foundation, January 1994.

[34] American Health Security Act, Sec. 1345.

[35] Mark V. Pauly, "Killing With Kindness: Why Some Forms of Managed Competition Might Needlessly Stifle Competitive Managed Care," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls*, (Washington, DC: AEI Press, 1993), p. 159. Pauly speculates that perhaps 5 percent or less of the population would be required to pay premiums of 50 percent more than the standard premium. However, Stanford professor Alain Enthoven, the "father of managed competition," believes that Pauly has underestimated the number who would have to pay significantly higher premiums. See Alain Enthoven, "The Effects of Managed Competition: Theory and Real-World Experience," in *Health Policy Reform,* p. 222.

[36] Data obtained from Milliman & Robertson.

[37] "Perspective on Small Group Market Reform," study conducted by Community Mutual Insurance Company, September 1991. See Supplemental Reading section, p. 30.

[38] Ted A. Lyle and Janet M. Carstens, "Actuarial Review of Proposed Small Group Reform Legislation in Ohio," study conducted by Community Mutual Insurance Company, November 29, 1991. See Sec. 3924.05.

[39] Source: Golden Rule Insurance Company. Golden Rule offered no-questions-asked health insurance policies for employers with 10 to 25 employees. The surcharge for the no-questions-asked groups ranged from 15 to 20 percent above what the same group could get if they provided health information in their application. There were also some restrictions.

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

[41] In a recent backgrounder, Stuart Butler of the Heritage Foundation argued in favor of guaranteed issue insurance and against risk pools. See Stuart Butler, "Reforming Health Insurance: Analyzing Objections to the Nickles-Stearns Bill," Heritage Foundation Issue Bulletin No. 193, June 14, 1994. Butler argues that such risk pools would inevitably be expanded to cover more and more people and that they would become an entitlement program (p. 14.) But that has not been the experience in the 28 states that already have such pools. Most people do not stay in risk pools for very long and the annual turnover rate is quite high — between 30 and 60 percent. The reason is that people have incentives *to get out of risk pools and find coverage elsewhere* precisely because risk pools charge above-market premiums. Butler argues as well that the insurance industry would have "enormous" incentives to dump high-risk individuals into the pools by quoting high rates to anyone who might pose a

high cost in later years if they are renewed. But competition among insurers would produce actuarially fair rates.

Finally, Butler argues that the establishment of risk pools would become a new, *unfunded mandate* for the states. (p. 15.) Under intelligent health care reform, a requirement to establish risk pools would be coupled with a finding mechanism. However, even if risk pools did become an unfunded mandate for state governments, that burden would be trivial in comparison to the unfunded mandates Butler proposes to impose on the entire private sector.

[42] This is another reform criticized in Butler, "Reforming Health Insurance." Guaranteed renewability would apply to coverage for children born into a currently insured family. This means coverage under an existing policy would automatically apply to a child born during the year, and the next year the family could be charged only the additional standard rate for coverage for a new child, regardless of the child's health. Therefore, an insured family whose new baby was born with a severe chronic illness would not have to pay above standard rates. To the contrary, this is one of the possible events that a sound health insurance policy insures against. Guaranteed renewability would not create perverse incentives or have adverse policy effects because it does not involve changing plans.

[43] David F. Bradford and Derrick A. Max, "Soak-the-Young Economics of Clinton's Health Care Plan," American Enterprise Institute, 1994. An earlier version of this article appeared in the *Washington Times,* February 8, 1994.

[44] Ibid.

[45] Applies to firms with fewer than 50 employees. See William R. Jones, Charles J. Poe, and Jonathan M. Topodas, "Pure Community Rating: A Quick Fix to Avoid," *Journal of American Health Policy,* January/February 1993.

[46] The American Academy of Actuaries, "An Analysis of Mandated Community Rating," March 1993, p. 4. Unpublished.

[47] Tony Hammond, "The Facts on Community Rating," Health Insurance Association of America, May 1994.

[48] Leslie Scism, "New York Finds Fewer People Have Health Insurance a Year After Reform," *Wall Street Journal,* May 27, 1994.

[49] Ibid.

[50] Many insurance companies support modified community rating (rather than full community rating) because they believe it would allow them to remain financially viable, while meeting the concerns of the advocates of such regulation. But insurance companies, particularly managed care insurers, could survive even under full community rating, with the right overall structure of the regulatory framework. The social problem created by community rating is not the problem it creates for insurers, but rather the negative impact on the policyholders.

[51] The difference between community rating and managed competition is simply one of degree.

[52] While some bills would allow discounts from the standard community rates for such healthy behavior as refraining from smoking, no discounts would be provided for most of the behavior consistent with "traditional and family values."

[53] Butler argues that "insurers would have every incentive to reduce [their] higher-risk old business subject to regulation and replace it with unregulated 'new' business." By this he means that insurers would have incentives to dump policyholders (whose medical bills they are obliged to pay under guaranteed renewability) and sell policies to people who are healthy. See Butler, "Reforming Health Insurance," p. 11. This is the same incentive that everyone has to break an unprofitable contract. The incentive is of no consequence, because both the law of contracts and laws enforced by state insurance commisoners correctly prohibit breaching such contracts.

Consider a contract where party X has promised to sell coal to partyY for $1 per ton. Party X then finds that the coal costs $2 per ton to produce. Party X would have "every incentive" to break this contract. But the law correctly forces party X to perform the contract, as guaranteed renewability would effectively do for health insurance. Butler's "solution" to this non-problem, guaranteed issue and community rating for new applicants, is analogous to forcing party X to enter into additional losing contracts with other parties to sell coal for $1 per ton.

Butler argues that the way insurers would try to dump the insured who became sick would be to subject them to low quality care (pp. 11-12). People can avoid this problem, however, by choosing fee-for-service plans, under which the medical services are provided by independent doctors. For example, there has not been a significant problem in the current fee-for-service market, where guaranteed renewability often applies by contract or state regulation. Under this system, managed care plans also have incentives to provide good quality care to the sick. Because the most important factor in choosing an insurer is how people are treated after they get sick, if insurers develop a reputation for mistreating policyholders who are sick, they will find it impossible to sell policies to healthy people.

Butler proposes to deal with this supposed problem through guaranteed issue and community rating, enabling sick patients to switch to other plans at no extra cost. But this would be of no help, under the logic of Butler's argument, since no insurer

would provide good quality care for the sick and risk attracting money-losing new business. Under Butler's proposed system, healthy people would still be attracted to such plans because they could enjoy lower costs there while they are healthy, and would have the right to switch to another plan as soon as they become sick.

Butler argues as well that guaranteed renewability would cause higher premiums for the healthy. Ibid., p. 12. But guaranteed renewability merely enforces the contract that insures against illness. Insurance that can be cancelled or prohibitively priced after the insured becomes ill is no insurance at all. Consequently, guaranteed renewability simply prohibits fraudulent insurance contracts. Undoubtedly, insurance that insures against becoming sick would cost more than "insurance" that does not. But Butler's argument is like complaining about a requirement that auto makers sell only cars with engines that work, on the grounds that such cars would cost more than those with engines that do not work. Moreover, the Heritage proposal that Butler advocates includes guaranteed renewability, guaranteed issue *and* community rating, which would raise premiums for the healthy even more than guaranteed renewability alone.

Others argue that health insurers today do not vary premiums for new applicants due to health condition, as indicated by their standard insurance rate books. But insurers today generally exclude preexisting conditions or deny coverage altogether for new applicants who are sick. Otherwise, insurance companies experience-rate, varying premiums based on health status.

[54] See Congressional Budget Office, *Managed Competition and Its Potential to Reduce Health Spending* (Washington, DC: CBO, May 1993), p. 8.

[55] In his 1994 State of the Union message, President Clinton said that the goal of his health care reform proposal is "to give every ... American the same health care security they have already given to federal employees." The Federal Employees Health Benefits Program (FEHBP) also has been held up as a prototype for reform by Alain Enthoven (see Note 35). Liberal Senator Edward Kennedy has advocated allowing individuals and small business employees to join the FEHBP. And the program has been praised by a number of conservative Republicans.

[56] Despite glowing descriptions of the FEHBP by its defenders, the Office of Personnel Management, which manages the program, and other analysts both inside and outside of government have identified its many flaws. See Janet P. Lundy, "The Federal Employees Health Benefits Program," Congressional Research Service, CRS Issue Brief, updated June 11, 1992; and "Statement of the Consultants of the Committee on Post Office and Civil Service Before the Subcommittee on Compensation and Employee Benefits," testimony before the House Subcommittee, May 20, 1992. For a summary of problems with the FEHBP, see "Federal Employees Health Plan: Model for Reform?" National Center for Policy Analysis, NCPA Brief Analysis No. 107, June 13, 1994.

[57] This section and the one following are based partly on John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," National Center for Policy Analysis, NCPA Report No. 183, April 19, 1994.

[58] In today's market, people are primarily buying insurance rather than medical services. For that reason, if an insurer mistreats policyholders after they become ill, everyone has an incentive to avoid that insurer. The primary reason why people insure, after all, is to be well-treated if they become sick. Under the Clinton plan, people could switch insurers after they became sick and would have an incentive to choose a plan based on their health condition and the plan's reputation for treating that condition, not on the plan's reputation as an insurer.

[59] A different way of appreciating this result is to consider it in terms of a basic principle taught in all introductory economics courses: when firms are maximizing profits, marginal revenue must equal marginal cost. Under managed competition, marginal revenue (the amount of premium each enrollee brings to a plan) must be the same for every enrollee. That means that marginal cost (the amount the plan spends on health care for a patient) must also be the same for every enrollee.

The Clinton plan tries to deal with the problem of "adverse selection" through a risk adjustment mechanism. See Ferrara et al., "The Clinton Plan." The National Health Board would guide each regional alliance in taking away some of the income of the health plans with lower-risk patients and giving it to those with higher-risk patients.

The most common risk adjustment proposals would tax or subsidize health plans based on the health of people *at the time they joined a plan.* Thus, sicker people would have a subsidy added to their premium payments and healthier people would have a tax deducted from theirs. Although enrollees would *pay* the same community-rated premium, health plans would *receive* a readjusted premium. In theory, this would make the health plans indifferent between potential enrollees. In fact, health economists have concluded that no more than 20 percent of the variation in health expenditures can be predicted based on prior information about enrollees. Therefore, even in principle, no risk adjustment mechanism could compensate health plans for more than 20 percent of the potential adverse selection. If adjustments cannot solve the problems based on *prior* knowledge of patients, the only alternative is to base them on *past* knowledge, the experiences of patients after they enroll. The problem is that if we reimbursed health plans for what they spend, we would merely replicate our existing cost-plus system. On the other hand, if we paid health plans based not on actual costs but on fixed fees determined by diagnoses, we would mirror the problems of Medicare reimbursement. See Goodman and Musgrave, "Primer on Managed Competition."

In any event, it is unlikely that any insurer would willingly attract all of the sickest patients in the area by providing them with the highest-quality care and risk relying on government to bail it out with income redistribution. Government bureaucrats would tend to be biased against major redistribution, as this would undermine their overriding cost control and global budget policies. For all of these reasons, the risk adjustment process would not work.

The Heritage Foundation supports a risk adjustment mechanism that works like this: If a person who is sick switches health plans, the procedure would allow the new insurer to recoup medical expenses for the enrollee from the prior insurer and pass back the premiums to that insurer. This would only create a morass of litigation as the old insurer challenges the expenses, treatments and procedures of the new insurer and insists that much cheaper treatment would have been sufficient, and contends that health status worsened after the transfer. You can not have a viable system when one health plan is providing the treatment and another is paying the bills. This mechanism in any event would not lead health plans to go all out to attract and treat the sickest patients. To the contrary, health plans would avoid the sick because of uncertainty about the amount of expenses they will be able to recoup from a prior insurer. To the extent that they are forced to accept and treat sick patients who are transferring from another insurer, health plans will have an incentive to spend no more on treatment than the amount they think they will be able to recoup. Nor can this problem be solved through quality control regulations. Quality health care would not result from creating incentives for health plans to provide poor-quality care, then relying on government regulators to keep them from doing so. Quality care would result only from market incentives to provide that high level of care.

[60] For a more thorough discussion of the Clinton plan's system of global budgets and price controls, see Ferrara et al., "The Clinton Health Plan," pp. 8-11.

[61] American Health Security Act, Sec. 6001.

[62] Robbins and Robbins, "Forecasting the Effects of the Clinton Plan."

[63] There is no reason to think that centrally established limits on health care spending would somehow eliminate "waste" and only waste. Indeed, the experience of other countries shows that global budgets create waste and inefficiency. See John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 166, December 1991.

[64] See Michael Walker and John C. Goodman, "What President Clinton Can Learn From Canada About Price Controls and Global Budgets," National Center for Policy Analysis, NCPA Backgrounder No. 129, October 5, 1993; and Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum,* May 1993, Fraser Institute, Vancouver, BC.

[65] Miyake and Walker, "Waiting Your Turn."

[66] See "The Crisis in Health Care: Sick to Death," *Maclean's*, February 13, 1989.

[67] "Humans Wait in Pain, Dogs Don't: Brain-Scan Use at Ontario Hospital," *Daily Mercury*, Guelph, Ontario, June 14, 1991.

[68] For further discussion of Medical Savings Accounts, see John C. Goodman, and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis*; John C. Goodman and Gerald L. Musgrave, "Medical Savings Accounts: An Idea Whose Time Has Come," National Center for Policy Analysis, NCPA Policy Backgrounder No. 128, July 22, 1992; John C. Goodman and Gerald L. Musgrave, "The Economic Case for Medical Savings Accounts," paper presented at the American Enterprise Institute, April 18, 1994; "Medical Savings Accounts: The Private Sector Already Has Them," NCPA Brief Analysis No. 105, April 20, 1994.

[69] See "Medical Savings Accounts: The Private Sector Already Has Them."

[70] See John Merline, "Employees as Health Reformers," *Investor's Business Daily,* March 18, 1994; Rachel Wildavsky, "Here's Health-Care Reform That Works," *Reader's Digest,* October 1993; Rosalind Resnick, "Enlisting Employees in the Battle to Cut Health Care Costs," *Business & Health,* June 1993, pp. 24-29; Chris Warden, "Letting Employees Rein In Costs: Firms Save on Health Care by Letting Market Work," *Investor's Business Daily,* May 20, 1993; and Goodman and Musgrave, "Medical Savings Accounts: An Idea Whose Time Has Come."

[71] Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis," Seventh Edition, August 1993; and Karl J. Knable, Morris Melloy and C. Keith Powell, "State Health Insurance Risk Pools," *Health Section News*, April 1991.

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