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Evaluating Senator Dole's Health Care Plan

Senator Bob Dole (R-KS) has proposed a health care reform plan that has already won the support of 40 Republican senators, the U.S. Chamber of Commerce, the National Federation of Independent Businesses (NFIB), the National Association of Manufacturers, the National Association of Retailers, the National Association of Wholesalers and many other organizations. Currently, the bill has more Senate supporters than any other health care proposal and serious prospects of gaining Senate passage.

"The Dole proposal avoids most of the bad features of the Clinton plan."

The Dole proposal avoids most of the bad features of the Clinton health care plan and its various derivatives. A true market-based alternative, it includes many of the reform ideas developed by the National Center for Policy Analysis.

However, the proposal's unnecessary, counterproductive insurance regulations need to be replaced, and details of its positive reforms can be significantly improved. This backgrounder discusses what is right in the Dole plan, why it is superior to Clinton-style plans and how it can be improved.

Avoiding Clinton's Mistakes

The Dole plan does not include the following undesirable components of the Clinton proposal and congressional versions of that proposal.

No Employer or Individual Mandates. Whether they are initially imposed on employers or on individuals, mandates impose a heavy burden on employees. Economists are virtually unanimous in the belief that employers pass the cost of mandates on to employees by reducing wages or, where they can't reduce wages enough to absorb the costs, by eliminating jobs. Mandates also lead inevitably to government control of the health care system. That's because once government defines the required benefit package, people will pressure the government to keep the price of that package down. Even if such

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provisions are not in the initial proposal, price controls, global budgets and health care rationing are natural consequences of health insurance mandates.[1] The Dole plan wisely avoids them.

No Global Budgets and Price Controls. In other countries, governments arbitrarily limit the funds available to hospitals and area health authorities, forcing doctors to ration health care. The Clinton plan adopts the same approach by limiting the amount health plans will have to spend on their patients through budget caps and price controls.[2]

No Mandatory Health Alliances. Under the Clinton plan, most people would be forced to buy their health insurance through government-sponsored, monopolistic bureaucracies, choosing only among the insurers offered by the alliance in their area. In the four versions of the Clinton plan passed out of congressional committees, the alliances are not mandatory. But most people would be forced into them anyway.[3] Individual choice and control over health coverage and care would dwindle, then disappear.[4]

No Government-Defined, Standard Benefit Package. The Clinton plan attempts to impose a government-chosen benefit package on everyone. Consumers would be forced to pay for benefits they may not want, including abortion, drug and alcohol rehabilitation, mental health counseling and coverage for routine care that would be cheaper if paid for directly. People would also be forced to accept low deductibles, even though their total financial exposure would be higher than under many existing high-deductible plans.[5] These benefits all add to the costs of coverage, and over time the special interests would probably succeed in adding more.[6]

"Resisting pressure from some Republican colleagues, Dole has rejected managed competition."

No Managed Competition. Managed competition is a set of complex regulations creating an artificial, government-controlled health insurance market. Health economists have shown that the incentives arising from such a system would destroy the quality of health care for the sick, who now receive by far the best health care in the world.[7] Although President Clinton claims his plan was designed to implement managed competition, most Democrats in Congress have refused to endorse the idea. Nonetheless, its structure is embedded in all four congressional versions of the Clinton plan.[8] Despite pressure from some of his Republican colleagues to hop onto the managed competition bandwagon, Dole wisely refused.

No Other Government Interference With the Practice of Medicine. The Clinton plan and its incarnations on Capitol Hill would effectively force people into HMOs or similar managed care plans in which bureaucrats would interfere with the doctor-patient relationship, perhaps denying access to specialists and specialized care. It also would create a regulatory and bureaucratic gauntlet that would stifle the development and adoption of new health care technologies. It would establish national practice guidelines that would effec-

tively shift control over health care from individual doctors to government bureaucrats. And it would allow quotas and controls over health care education to limit and reduce the supply of medical specialists who provide the highest-quality care.[9] The Dole bill avoids these unwise measures.

No National Health Board or Other New Bureaucracies. The Clinton plan would create 59 new government bureaucracies or programs, including a powerful National Health Board.[10] These bureaucracies would add to costs, bind health care in bureaucratic red tape, reduce the quality of care and shift control over health care to the government. The Dole bill, by contrast, includes no new government bureaucracies.

No New Taxes. The Clinton plan and related congressional bills would impose new and higher taxes on the middle class. The bill reported out of the House Ways and Means Committee would impose a new 2 percent tax on health insurance premiums. The Senate Finance Committee would assess a 1.75 percent tax on premiums. It would also impose an additional tax on the premiums of the highest-cost 40 percent of health plans in each area, equal to 25 percent of the difference between their cost and the average cost plan in the area. These taxes would ultimately be paid by employees.

"In contrast to the various incarnations of the Clinton plan on Capitol Hill, the Dole plan contains no new taxes."

Clinton's plan and all four bills reported out of congressional committees would also abolish Flexible Spending Accounts, which allow employees to pay unreimbursed health expenses with pretax dollars, and all would impose stiff new cigarette taxes.

The Dole proposal, by contrast, includes none of these new taxes.

The Best Provisions in the Dole Bill

The Dole bill not only avoids the mistakes of the Clinton plan, it proposes a package of free market reforms that would genuinely improve our health care system. What follows is a brief summary.

Medical Savings Accounts. Dole would allow employers to offer their employees Medical Savings Accounts (MSAs) plus catastrophic insurance in place of conventional insurance. Under this option, employers would pay a reduced premium for catastrophic insurance with a high deductible, say $3,000 per year. The rest of the money would go into a tax-free Medical Savings Account for each employee. The employee would pay health expenses below the deductible with their MSA funds.

"Medical Savings Accounts would allow people to control most of their own health care dollars."

As a result, consumers would have incentives to control costs by avoiding unnecessary expenses. Perhaps more importantly, in response to increased consumer concern, doctors and hospitals would compete vigorously to reduce costs while maintaining quality. An MSA is the only cost control vehicle that relies on economic incentives for consumers and competition

among providers. It also is the only reform option that addresses the root cause of rapidly rising health costs: third-party payment of medical bills.[11]

Tax Fairness. The Dole bill would allow individuals a full income tax deduction for the health insurance they purchase directly rather than through their employers, giving everyone the same tax relief.[12] This reform not only achieves simple fairness, it also achieves other socially desirable goals. It would allow employees to buy fully portable individual insurance without tax penalty, eliminate the tax code tie between insurance and employment, help the currently uninsured obtain coverage and discourage people from waiting to obtain insurance through an employer.

Guaranteed Renewability. The Dole bill requires guaranteed renewability for all insurance policies. This provision would prohibit insurers from canceling coverage or raising premiums because a person gets sick. Insurers would be required to renew coverage at the same standard rate increases for everyone with the same policy.

This reform requires that insurance contracts incorporate the concept of coverage against the high costs of illness, standard practice in the individual insurance market. The reform is consistent with what people think they are buying when they purchase health insurance. Health "insurance" that can be canceled or prohibitively priced after the insured becomes sick is not real insurance. It does not protect against high medical costs. Just as an insurance company cannot be expected to provide fire insurance after a house has caught fire, the company cannot be allowed to cancel or add charges to an existing fire insurance policy once the house is burning.

"Insurers could not cancel a policy or increase premiums after a person gets sick."

Vouchers. For all individuals and families who are below the poverty line but not otherwise covered, the Dole bill would provide vouchers to pay for essential health coverage from the insurers of their choice. The subsidy amounts fall as income rises above the poverty level, eventually reaching zero at 150 percent of poverty.

The vouchers would assure that no one lacks essential health coverage because they are poor, but they would not interfere with the health insurance market. The Dole proposal also specifies reasonable limits on the subsidies, making the costs manageable. Important improvements that should be made to this proposed low-income assistance plan are described below.

Repeal of State-Mandated Benefit Regulations. The Dole plan would allow insurers to offer health policies without benefits that otherwise would be required under state law. Such state-mandated benefit laws force on consumers the benefits favored by special interests, unnecessarily restricting consumer choice and adding costs. The Dole proposal would allow consumers to choose their benefits and buy lower-cost, no-frills policies. The lower

insurance costs should help the uninsured obtain coverage, since state-mandated benefits are estimated to have priced as many as 25 percent of uninsured individuals and families out of the market.[13]

Making the Dole Plan Better: Deleting Unnecessary Insurance Regulations

"The plan includes some harmful and unnecessary regulations."

The Dole plan has at least one major problem that needs to be corrected, and it can be improved in other important ways. The major problem is the inclusion of unnecessary, ultimately harmful health insurance regulations. The troublesome provisions are:

- **Modified Community Rating**. Insurance sold to individuals or groups of 50 or less would be subject to federal premium regulation known as modified community rating. Under such regulation, insurers could vary premiums only for age, family size and geographic area. The maximum variation for age would be limited by a factor of 3:1 for the highest rate compared to the lowest rate. Insurers could not vary premiums due to health status, risk or medical expenses previously incurred.
- **Guaranteed Issue**. Insurers would be required to accept and cover all applicants regardless of health status or risk.
- **Risk Adjustment.** For insurance sold to individuals or small groups of 50 or less, states would have to develop and implement risk adjustment systems. Under these systems, regulators would take funds from health plans with healthier, lower-risk enrollees and transfer them to plans with less-healthy, higher-risk enrollees.

Inherent in such regulations are problems that we have analyzed at length elsewhere.[14] The following is a brief summary.

Risk of Too Much Regulation: Forcing Most to Pay More. The regulations would force most people to pay more for their health insurance. Under the guaranteed issue requirements, sick people who are currently uninsurable would be able to buy insurance. Yet under the community rating requirements, they would be paying only a small portion of the cost of their care, which would mostly be paid through higher premiums for everyone else. Premiums would inevitably rise, and some of the healthy would drop their insurance, knowing that they could buy coverage at standard community rates if they became sick. As low-cost healthy people dropped out, premium costs for those who remained would have to rise even more, resulting in what's known as a "death spiral." There are several estimates of the likely increase of premiums that would result from this process:

"Under community rating, the healthy would be overcharged — encouraging them to go uninsured until they get sick."

- Milliman and Robertson, Inc., a prestigious actuarial firm, estimated 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.[15]
- Community Mutual of Ohio, a Blue Cross/Blue Shield company, estimates that such regulation would increase its premiums by 20 to 25 percent.[16]
- Tillinghast estimates that a similar plan in the state of Ohio would increase premiums by 11 to 47 percent.[17]
- The actual experience of the Golden Rule Insurance Company under guaranteed issue was an increase in claims costs of over 50 percent the second year and increases of 30 to 35 percent thereafter.[18]

When these premium increases materialize, angry constituents may vent their wrath on the responsible congresspersons. Those who oppose insurance reform may also seize upon the increases, using the anger they provoke to push for government control of health care.[19]

Risk of Too Much Regulation: Regressive Hidden Taxes. The premium increases described above would effectively be a regressive hidden tax. Premiums would rise by a flat amount unrelated to income, which would be a higher percentage of the incomes of the less affluent. For example:

- If the proposed health insurance regulation causes the premiums for family policies to rise by $1,000, that's a 10 percent tax on a family with a $10,000 annual income, but only a 1 percent tax on a family earning $100,000.
- As a result, the tax rate on the family with a $10,000 annual income would be ten times as high as that for a $100,000-a-year family.

"The attempt to subsidize premiums for those who are already sick would impose a regressive, hidden tax on low-income people."

Moreover, the healthy people who would tend to pay more under community rating requirements would, on average, be younger and less affluent. Yet the sick people who would be subsidized by premium increases would, on average, be older and more affluent.[20]

Risk of Too Much Regulation: Increasing the Number of Uninsured. Contrary to widespread impressions, most of the 39 million people who are currently uninsured are healthy. Sixty percent of the uninsured are under age 30 and in the healthiest population age group.[21] These young workers have below-average incomes and few assets. As a result, they tend to be very sensitive to premium prices. Indeed, the primary reason why most of the uninsured lack health coverage is that they have judged the price too high relative to the benefits. Only about 2 million of the uninsured have been denied coverage because of their health condition.[22] The premium increases

that would result from the proposed regulation would merely increase the number of uninsured.

- The National Center for Policy Analysis/ Fiscal Associates Health Care Model predicts that, other things being equal, a 10 percent increase in premiums would lead to a 6 percent reduction in the number of people who are insured.
- The study by Milliman and Robertson of the proposed guaranteed issue regulation for New Hampshire estimated that it would cause 20 to 25 percent of the state's policyholders to drop their coverage.[23]
- In just the first year of pure community rating in New York state, about 44,000 individual policyholders canceled their coverage because of rising premiums.[24]

Risk of Too Much Regulation: Taxing Traditional Family Values. The proposed regulations would also undermine the traditional and family 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 monogamous sexual practices, avoidance of drug and alcohol abuse 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 that those who do not can pay less. Effectively, community rating taxes traditional and family values and subsidizes their opposites.[25]

"People should pay more for insurance if they voluntarily choose riskier lifestyles."

Risk of Too Much Regulation: Encouraging Unhealthy Lifestyles. Indeed, because community rating prohibits higher premiums due to the health status of applicants, it means that those who pursue unhealthy behavior of all kinds will pay less, while those who pursue healthy behavior will pay more to make up the difference. As a result, unhealthy behavior is rewarded and encouraged while healthy behavior is penalized and discouraged. In other words, community rating would reward smoking, overeating, alcoholism, drug abuse and promiscuity of all kinds. It would penalize abstinence, healthy eating habits, exercise, monogamy, fidelity and marriage.[26]

Making the Dole Plan Better: Adding Risk Pools

Risk pools make health insurance available at affordable premiums for people who are otherwise uninsurable because of their health status. Adding such risk pools to the Dole plan would allow the plan to achieve all of the desirable goals of insurance reform while at the same time deleting guaranteed issue, community rating, and risk adjustment regulations — thereby avoiding the intractable problems these regulations would create.

Indeed, risk pools, along with guaranteed renewability and voucher provisions already in the bill, would effectively provide universal access to health insurance. The guaranteed renewability would assure that coverage for everyone with insurance would continue. The vouchers would ensure everyone the necessary funds to obtain coverage. And the risk pools would provide coverage for those who became uninsurable while not covered.

State Uninsurable Risk Pools. Each state could establish an uninsurable risk pool. Such pools would provide essential coverage to individuals who become sick and uninsurable in return for higher premiums up to some reasonable maximum limit, perhaps 25 percent to 50 percent more than standard rates. The premiums could be related to the income and assets of each applicant and could be coordinated with the vouchers described above, so that no one was excluded because of a lack of resources. People who became sick while they are willfully uninsured could be charged higher rates than those who are uninsured through no fault of their own. Because risk pools usually lose money, each state would have to subsidize the costs not covered by premiums. The best way to fund the subsidies would be from general revenues.

"More than half the states already have risk pools."

Risk pools are already in operation in 28 states and cover about 100,000 people, although they are not always fully funded. One recent study found that extending risk pools nationwide to cover all uninsurable people would have cost only about $300 million per year in state subsidies in 1989, less than one-tenth of one percent of the nation's annual health care bill.[27] That's because only 0.7 percent of the U.S. population has been denied health insurance due to a medical condition, according to the U.S. Public Health Service.[28]

Nebraska offers an example of how risk pools can work. Any resident who has been denied health insurance within the last six months can join the state's 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). The risk pool covers about 3,300 people, about 0.2 percent of the state's population. A family of four can join the pool for about $400 per month.[29]

Risk Pools and Other Insurance Regulations. Risk pools and guaranteed renewability together eliminate the need for guaranteed issue regulations and modified community rating in the following way. Under guaranteed renewability, insurers could not vary premiums based on health status, risk or medical expenses incurred for those they had already insured, because such variation is exactly what the consumers had insured against in purchasing the health insurance policy. All new applicants, however, would be charged actuarially fair rates reflecting their present and future health risk at the time they joined the plan.[30]

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

Under this system, consumers could eliminate premium or cost variations due to health condition or risk by purchasing insurance before they became sick. Those preferring to eliminate only extreme variations could buy catastrophic policies with higher deductibles, and those preferring to eliminate almost all variations could buy policies with low deductibles. The sick could not impose their costs on those in a plan they did not contribute to while they were healthy, because they would be charged actuarially fair rates reflecting their health risk upon entry. The healthy would have no incentive to drop coverage because they would not be guaranteed coverage at standard rates if they later became sick.

Through such risk pools, those who failed to buy insurance when they were healthy, and then became uninsurable, would be able to obtain coverage with reasonable premium limits.

Achieving Portability. These reforms would work even better if employer-provided coverage were fully portable, so that workers could take their insurance with them from job to job. The Dole proposal moves in this direction by allowing full deductibility for health insurance purchased directly by individuals. MSAs financed by employers or individuals should also be fully portable. To avoid any difficulties with traditional employer-provided insurance, the tax exemption for such insurance should be allowed only if the insurance is personal and portable. Employers could buy individual policies for each employee — policies the employees could take with them when they switched jobs. Or employers could buy group insurance with the option for employees to convert to individual policies when they leave their jobs. Companies that self-insure would have to contract with an insurer for such portability or continue to provide the coverage themselves. These companies could also be allowed to form joint insurance operations to provide such coverage.[31]

Making the Dole Plan Better: Achieving Universal Coverage Without Mandates

"The extra taxes paid by the uninsured could fund the uncompensated care they receive."

A common assumption in the current health care debate is that universal health insurance coverage can only be achieved through an employer or individual mandate. Either directly or indirectly, these mandates would require individuals to obtain health insurance, whether they want to or not.

An Alternative to Mandates. Fortunately, there is a better way. Government could make health insurance affordable for every family through a system of tax credits, similar to the low-income subsidies in the Dole plan. Under this system, people who choose to be uninsured would not get a tax subsidy and thus would pay higher taxes. The revenues can be used to fund a

social safety net that would work in the following way. Uninsured people would be entitled to obtain medical care regardless of financial means — although they probably would not have access to every doctor and hospital. Moreover, when they obtained medical care, the voluntarily uninsured would be payers of first resort, relying on the safety net only after exhausting their own resources.

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 they receive each year. The problem with the current system is that the extra taxes paid by the uninsured go to Washington, while the free care they get is furnished by local providers. The need is to return those taxes to the communities where the uninsured live.

Other Reforms. Further reforms, already in the Dole plan, would encourage people to become continuously insured, making both risk pools and the social safety net less necessary. 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.
- 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.
- Refundable tax credits would provide the poor with the funds to purchase essential health coverage.
- Guaranteed renewability would prohibit insurers from canceling policies or subjecting policyholders to sharp rate hikes if they got sick.
- Portability would assure that people would not lose their coverage when they switched jobs.

Making the Dole Plan Better: Creating More Options for Low-Income Families

"Government should allow low-income families to choose the health benefits they want to buy."

As discussed above, the Dole bill would provide vouchers to low-income individuals. Those receiving Medicaid, Medicare or employer-provided insurance would not be eligible. Otherwise, for those individuals and families below the poverty line,[32] the vouchers would pay part of the premiums for a specific package of benefits.[33] The income subsidies would be phased out between 100 and 150 percent of poverty-level income.[34]

The chief problem with this proposal is that the government would specify the benefits — called the Fed Med benefit package — to be purchased with the vouchers. This would create a political bidding war, dominated by special interests, over what benefits to include in the package. The result would be a package far more expensive than is necessary, one that does not necessarily include the benefits the people being helped want. In addition, the battle over inclusion of abortion services would be highly contentious. A Fed Med package might even provide the foundation for a single, universal, government-defined benefit package mandated for everyone.[35]

Vouchers Without a Government-Defined Benefit Package. The government need not and should not specify the benefits that must be purchased with the vouchers. It should only specify the amount of money each voucher is worth.[36] The recipients would then be free to choose their insurance and their benefits.

Vouchers for Medicaid Recipients. The vouchers should replace rather than supplement the Medicaid program, which is characterized by runaway costs — and, all too often, low-quality care. The poor would be much better off with vouchers that would enable them to participate in mainstream health care. The vouchers also would help to keep the government's expenditures defined and manageable.

"Medicaid should be replaced with a system of vouchers."

Specifically, Medicaid funding should be separated into two block grants to the states. One would continue the Medicaid long-term care benefits, which the states can provide under current rules. The second block grant would finance the vouchers and state uninsurable risk pools. The block grants should provide a flat amount to each state, which can be supplemented as the state chooses, rather than a matching percentage of state spending, which encourages more spending. The federal grant amounts should be high enough so that the states would not have to spend more than they are currently spending for Medicaid and risk pools.

Making the Dole Plan Better: Expanding the Role of Medical Savings Accounts

The bill would allow annual tax deductible MSA contributions of $2,000 for single persons and $4,000 for families. In addition, people would be able to make tax deductible payments for catastrophic insurance. Distribution from the MSA for medical expenses would be tax free. Other withdrawals would be subject to full income taxation and a 10 percent penalty.

"Withdrawals from MSAs should be subject only to ordinary income taxes."

Eliminate the 10 Percent Withdrawal Penalty. MSAs are designed to encourage consumers to control costs and to stimulate competition that leads providers to control costs as well. For the design to work, people must get a reward from their MSA funds. If they can only spend MSA funds on

health care now or in the future, they would have weak incentives to avoid unnecessary health expenditures. The broader the alternative ways to spend MSA funds, the stronger the incentives to control costs.

For this reason, the 10 percent penalty on withdrawals for nonhealth expenses should be deleted. Removing the penalty would allow consumers to withdraw saved MSA funds at year's end or thereafter, for any purpose, subject only to normal income taxation.

Allow MSA Funds to Accumulate Tax Free. The Dole proposal also taxes the income earned on MSA funds as it is earned, unlike IRAs whose returns are exempt from taxation until withdrawn. Such taxation would reduce the degree to which MSAs are utilized and reduce the proposal's cost-curbing impact.

"Like IRAs, MSAs should be allowed to grow tax free."

MSA taxation would not, in any case, result in a significant revenue gain for the government. Studies show that deposits to IRA accounts (1) mainly constitute new savings, (2) finance new investment which makes possible more output and higher tax revenues for government and (3) cause a net increase in revenue for government.[37] In terms of government revenue, IRAs more than pay for themselves. The same would be true of MSAs.

MSA investment returns should be exempt from tax until withdrawn, like IRAs. This would maximize the appeal of MSAs and the degree to which they would reduce health costs.

Allow Rollovers Into IRAs at Retirement. The Dole proposal also prohibits any rollover of MSA funds into IRAs or other pension plans at retirement. But if the returns on MSA savings are tax exempt and MSA funds can be withdrawn for nonhealth expenses without penalty, there is no reason to prohibit such rollovers. They would simply allow retirees to consolidate their savings and perhaps save some administrative expenses.

Allow Tax-Free Transfers to a Spouse at Death. The Dole plan prohibits the transfer of MSAs at death and makes the funds taxable to the decedent. It should instead allow a surviving spouse to inherit the MSA. This would prevent the death of one spouse from depriving the other of the MSA when it may be most needed. Moreover, the government should not tax away from the surviving spouse the resources an elderly couple has saved together.

Allow Other Innovative Uses of MSAs. The Dole plan should also incorporate the following provisions:

- **MSAs for Federal Employees.** The federal government should allow an MSA option for its employees under the FEHBP. This would reduce the government's health expenses under the program, as MSAs have done for private employers,[38] and would encourage other employers to adopt MSAs and reap the cost reductions that ensue.

- **MSAs for Low-Income Families.** The government should allow use of its health care vouchers to fund MSAs. This would enable those with lower incomes to gain from wise use of their MSA resources and would further contribute to reducing health care costs.
- **MSAs for the Elderly.** The government should also allow an MSA option for the elderly under Medicare. The per capita amount spent under Medicare each year could be contributed to an MSA at the retiree's option, with some of the funds going for catastrophic insurance. Not only would this contribute to cost reduction, but the benefit would go directly to the elderly.[39]

Making the Dole Plan Better: Eliminating Other Unnecessary Regulation

"Washington cannot possibly be better at choosing insurance benefits than people who are buying the coverage."

The Dole plan requires that every insurer selling to the individual or small group market or through a purchasing cooperative offer the Fed Med benefit package as an option. This is unnecessary, as the market will offer the full range of benefit packages consumers desire. Washington bureaucrats cannot possibly know more than decentralized insurance marketplaces about what benefits consumers want.

In addition, the plan requires the Secretary of Health and Human Services to develop comprehensive guidelines for state certification of health plans, which states are then required to implement. This mandate violates the basic principles of federalism. States have long performed this function themselves, and they can continue to do so.

Both of these requirements should be removed.

Conclusion

To summarize, the following changes should be made in the Dole proposal:

- Modified community rating of health insurance premiums should be deleted.
- Guaranteed issue of all health insurance should be deleted.
- Risk adjustment redistribution of health insurance premiums should be deleted.
- State risk pools for the uninsurable should be added.
- The tax exemption for employer-provided insurance should be allowed only if the insurance is personal and portable.

- The requirement that low-income vouchers be used only for a government-specified Fed Med benefit package should be deleted.
- Low-income vouchers should replace rather than supplement the failed Medicaid program.
- The 10 percent penalty on Medical Savings Account withdrawals for nonhealth care expenses should be deleted.
- The returns on MSA savings should be exempt from taxes until withdrawn.
- Rollovers of MSA funds into IRAs should be allowed after retirement.
- The survivor should be allowed to keep the deceased spouse's MSA.
- Federal government employees should be offered an MSA option under the Federal Employees Health Benefits Program.
- Low-income vouchers should be allowed for MSA purchases.
- Medicare should offer the elderly an MSA option.
- The requirement that every insurer offer the Fed Med benefit package as an option should be deleted.
- The provision for mandatory federal guidelines for state certification of health plans should be deleted.

"These reforms would create universal access to health insurance, without interfering with the marketplace."

Under these reforms, everyone — 100 percent of the population — would be able to obtain essential coverage. Those who have insurance would keep it through guaranteed renewability. Those who lack the funds to buy insurance could do so with vouchers. Even the uninsured who became uninsurable could obtain coverage through risk pools.

Further, these reforms include the only effective way to achieve cost control without government health care rationing: Medical Savings Accounts.

Finally, the reforms would shift power and control away from the government, insurance companies and employers to the people. With the changes outlined here, Senator Dole's proposed legislation would be a prescription for patient power and health care freedom.

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 further discussion, see Peter J. Ferrara, "The Health Policy Debate: Options for Reform," National Center for Policy Analysis, NCPA Policy Backgrounder No. 131, July 1994, pp. 2-7.

[2] For the experience of other countries, 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 Policy Backgrounder No. 129, October 1993; and 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. For an analysis of the Clinton plan's features, see Ferrara, "The Health Policy Debate," pp. 27-30; and Peter J. Ferrara et al., "The Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 184, May 1994, pp. 8-11.

[3] See "Managed Competition Is Back," National Center for Policy Analysis, NCPA Brief Analysis No. 118, July 1994.

[4] For further discussion, see Ferrara, "The Health Policy Debate," pp. 25-26.

[5] Under the Clinton plan's fee-for-service option, the deductible is only $200 per person. But the total exposure for a family (including copayments) is $3,000. If the proposal were adopted, it would outlaw health plans with higher deductibles ($1,000) but with much less exposure.

[6] Ferrara, "The Health Policy Debate," pp. 7-9.

[7] For further discussion, see John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," National Center for Policy Analysis, NCPA Policy Report No. 183, April 1994; Ferrara, "The Health Policy Debate," pp. 23-25; and Ferrara et al., "The Clinton Health Plan," pp. 14-17.

[8] See "Managed Competition Is Back."

[9] For further discussion, see Ferrara et al., "The Clinton Health Plan," pp. 11-20.

[10] Ibid, p. 1.

[11] For further discussion, see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992); 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 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; and "Medical Savings Accounts: The Private Sector Already Has Them," National Center for Policy Analysis, NCPA Brief Analysis No. 105, April 20, 1994.

[12] We are assuming an adjustment for FICA taxes on the tax returns of individuals who purchase insurance with aftertax dollars.

[13] See 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.

[14] See John C. Goodman, "Should Healthy People Pay More for Health Insurance," National Center for Policy Analysis, NCPA Policy Backgrounder No. 115, April 1992; Goodman and Musgrave, "A Primer on Managed Competition"; Ferrara, "The Health Policy Debate," pp. 13-25; and Ferrara et al., "The Clinton Health Plan," pp. 14-17, 33-36.

[15] Data obtained from Milliman and Robertson.

[16] "Perspective on Small Group Market Reform," study conducted by Community Mutual Insurance Company, September 1991. The proposed regulation was a reform plan developed by the Health Insurance Association of America (HIAA).

[17] 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.

[18] Data obtained from Golden Rule Insurance Company.

[19] For further discussion, see Ferrara, "The Health Policy Debate," pp. 13 ff.

[20] Ibid.

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

[22] Karen M. Beauregard, "Persons Denied Private Health Insurance Due to Poor Health," Agency for Health Care Policy and

Research, Public Health Service, AHCPR Report No. 92-0016, December 1991.

23 Data obtained from Milliman and Robertson.

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

25 While the Dole proposal would allow discounts for health-promoting activities, there is no way such discounts could be designed to take into account the sexual and personal lifestyle practices reflecting traditional family values.

26 Discounts for healthy practices might offset the problem for some of these factors to some degree, but such discounts would again be infeasible for most of them.

27 See Karl J. Knable, Morris Melloy and C. Keith Powell, "State Health Insurance Risk Pools," *Health Section News*, April 1991.

28 Beauregard, "Persons Denied Private Health Insurance Due to Poor Health."

29 For further discussion of risk pools, see "Risk Pools: A Better Solution for Preexisting Conditions," National Center for Policy Analysis, NCPA Brief Analysis No. 112, June 1994.

30 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. 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 policyholder gets cancer, he can expect his premium to increase sharply at the end of the year to recover the costs of treating his cancer.

31 For further discussion of guaranteed renewability, see Ferrara, "The Health Policy Debate," pp. 10-22.

32 Initially, full subsidies would be provided only up to 90 percent of the poverty level. They would be expanded to 100 percent in future years contingent on available funding.

33 The full subsidy would be set at up to the maximum contribution payable each year for a federal employee's insurance under the Federal Employees Health Benefits Program (FEHBP). The maximum contribution for each recipient would vary with geographic area, age and family size. The Secretary of Health and Human Services (HHS) would specify the benefits that must be covered, including — at a minimum — benefits required for the FEHBP and HMOs under federal law. Full parity would be provided for preventive services and for mental health and substance abuse services, with special consideration for the needs of children and vulnerable populations.

34 Subsidies for those between 100 and 150 percent of poverty would be contingent on available funding.

35 The problems of such a government-defined benefit package are further discussed in Ferrara, "The Health Policy Debate," pp. 7-9.

36 The legislation should require that the Secretary of HHS calculate the standard amount necessary to purchase essential health coverage. This would then be the standard amount of the vouchers. The vouchers would have to be coordinated with the state uninsurable risk pools to assure the sick and uninsurable sufficient funds to obtain coverage.

37 See Aldona Robbins and Gary Robbins, "The Case For IRAs," National Center for Policy Analysis, NCPA Policy Report No. 163, April 1991.

38 See "Medical Savings Accounts: The Private Sector Already Has Them."

39 See Goodman and Musgrave, *Patient Power*, ch. 15.

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