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Senator Mitchell's Last Stand

"The Mitchell bill has all of the major features of the Clinton plan in slightly different form."

The Senate is now in open debate on the health care reform bill proposed by Senate Majority Leader George Mitchell (D-ME). A composite, the proposal is based on bills written by the Senate's Finance and Education and Labor committees and on President Clinton's original proposal. Although we have been told repeatedly that President Clinton's health care plan is dead, the Mitchell bill has all of that plan's major features in slightly different form. Included are:

- Employer and individual mandates that would be inevitably "triggered" under the provisions of the bill.
- A global budget that would be enforced by a tax rather than by regulation.
- A uniform, government-specified benefit package that initially employers would be forced to offer to their employees and eventually everybody would be forced to buy.
- Community rating regulations, which would force insurers to sell to everyone at the same premium, regardless of expected health care costs.
- Health purchasing alliances that most Americans would be effectively pushed into.
- New federal bureaucracies such as a National Health Board, which would effectively control the nation's health care system.

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Indeed, the primary differences between the Mitchell plan and the Clinton plan are that Mitchell proposes even higher taxes on the middle class and even more government spending. Specifically, the Mitchell bill includes:

- A large new tax increase on the middle class — a 1.75 percent tax on health insurance premiums — that was not included in the original Clinton proposal.
- A new global budget tax of 25 percent on all health insurance plans that spend more on health care than is allowed under government-specified spending targets.
- Health insurance subsidies for a family of four up to 200 percent of poverty, or about $32,000 in income in 1994, and up to 300 percent of poverty, or close to $50,000 for pregnant women and children.

These and other new subsidies would cost over $100 billion per year by 1998, and the total cost of the program would exceed $1 trillion over the first eight years.

According to Senator Mitchell, this bill would solve the health care problems of the middle class. In fact, the bill would burden the middle class in the following ways:

- Employer and individual mandates would cause lost wages and lost jobs.
- The new global budget tax ultimately would tax fee-for-service plans out of existence and would force the remaining health plans to ration care.
- A uniform, government-defined benefit package would eliminate freedom of choice for all Americans.
- Provisions that would effectively force people into health insurance purchasing alliances would limit the number of insurers able to offer insurance coverage and further reduce freedom of choice.
- Community rating regulations would raise health insurance premiums for younger, healthier people with lower incomes and increase the number of uninsured until the mandates are imposed.
- Higher taxes on the middle class would equal almost $30 billion per year by 2000.
- Government spending for new subsidies, benefits and other programs would lead to higher taxes for the middle class in the future.

"In contrast to the Clinton proposal, Mitchell proposes even more government spending and higher taxes for the middle class."

These and other problems with the proposed legislation are discussed in greater detail below.

Employer and Individual Mandates

The Mitchell bill provides for an automatic employer mandate in every state in which less than 95 percent of the population is covered by health insurance by the year 2000.[1] The mandate would go into effect in 2002 and require employers with 25 or more employees to pay 50 percent of health insurance costs for their workers. No employer or small business subsidies are provided after this mandate is triggered.

The employer mandate would be accompanied by an individual mandate. Employees would be required to pay the other 50 percent of their health insurance costs, and those with no employer would be required to pay for 100 percent of the costs. This group includes small business owners, independent contractors and professionals, the unemployed and the nonemployed. Lower-income individuals would be eligible for subsidies, however, so that the 50 percent employee share would be no higher than 8 percent of income. People at or below the poverty level would pay no more than 4 percent of income. That limit would increase with income, reaching 8 percent at 200 percent of poverty.

"Government would force employers and employees to purchase health insurance in any state without 95 percent the people insured by the year 2000."

Despite substantial subsidies for individuals and for some employers, no state is likely to achieve 95 percent coverage by 2000. The average coverage nationwide is 85 percent and trending downward.[2] Even Hawaii, with a long-standing state mandate, has only 93 percent coverage.[3] Moreover, provisions of the legislation that are discussed below would likely increase the number of uninsured, so the employer and individual mandates probably would be triggered in every state. Indeed, the Congressional Budget Office (CBO), in its study of the Mitchell bill, concluded that mandates would be effective only if applied in all states. Otherwise, companies that employ people in many states would curtail operations in those states with mandates and expand them in those without.[4]

Employer mandates are an attempt by politicians to disguise the fact that the costs of employee benefits are a substitute for wages. Far from a free lunch, mandated benefits are paid for by employees, not employers. Standard economic analysis shows that employers would reduce the wages they would otherwise pay employees by the amount of the mandated insurance costs to keep total employee compensation equal to the value of worker productivity.[5] This wage offset is likely to be quite large, since the CBO estimates that the insurance package mandated under the Mitchell bill would cost almost $6,000 per year for a typical two-parent family.[6] Where employers could not compensate for the increased costs by reducing wages, they would lay off employees. This is more likely to happen to low-wage employees for whom the minimum wage law, union controls and other government regulations inhibit wage offsets.

Several econometric studies have estimated the magnitude of the wage and job losses that would result from a mandate requiring employers to pay 80 percent of health insurance premiums.

- The studies consistently found that Clinton-style mandates would cost about $100 billion per year in lost wages.[7]
- On the average, the studies predicted that the mandates also would cost the economy about one million jobs.[8]

Although the Clinton/Mitchell bill requires employers to pay 50 percent of premiums rather than 80 percent, the economic effects would likely be similar.

In addition to their economic cost, mandates also would inevitably lead to government control of the health care system. Mandates require that the government detail exactly what benefits people must buy. Those who are compelled by the mandate then demand that government keep down premium costs. The government is inevitably drawn into imposing global budgets and price controls, forcing providers to ration care. Ultimately, every decision about medical resources becomes a political decision made in Washington, D.C.[9]

The Global Budget Tax

"Mitchell would try to control costs by taxing high cost (read: high quality) health plans."

The Mitchell bill would effectively impose global budgets through a 25 percent tax on the insurance premiums of every health plan to the extent the plan exceeded government target limits on health care spending. The target limits would equal the rate of inflation plus 2.0 percent — cutting the annual health care spending growth rate in half. The growth rate has ranged around 10 to 12 percent over the past three decades.

The purpose of the tax is to drive high-cost health plans (which are often high-quality plans) from the market and to force plans that remain to limit the amount they spend on health services for their enrollees.

Result: Health Care Rationing. To the extent that health plans limited their spending to avoid the tax, they would arbitrarily reduce the resources available for health care for their enrollees.

- According to one recent study, meeting global budget goals similar to the ones in the Mitchell proposal would require a reduction in health care resources of 18 percent by the year 2005 — causing about one in six medical services to be rationed.[10]
- Another study concluded that the required reduction would be 24 percent by the year 2000 — causing almost one in four medical services to be rationed.[11]

Government-caused reductions in health care resources would lead to arbitrary reductions in the quality of care and access to care for middle-class patients. Doctors and hospitals would have to cut back on the services and care they provide to meet these resource limits. They would no longer be able to provide the best, most advanced, most sophisticated care. They would no longer be able to rapidly acquire and offer the latest innovations, newest technologies and most cutting-edge treatments. Over time, patients would be subject to long waiting lines and delays for diagnostic tests, surgery and other care, as patients are today under the global budget systems of England, Canada and New Zealand — three countries with cultures very similar to our own.[12]

"Reductions in health care resources would cause sharp and arbitrary reductions in the quality of care."

Result: The Demise of Fee-for-Service Plans. To the extent a health plan avoided such health care rationing, it would pay a 25 percent tax on its premiums that ultimately would be passed on to policyholders. Such a tax eventually would force fee-for-service plans out of existence, since such plans have no means to limit the health care spending of their enrollees. Unlike health maintenance organizations (HMOs), these plans do not employ their own doctors and cannot easily prevent doctors from providing their patients with the services they think their patients need. Thus the choice of a fee-for-service plan would be lost for the vast majority of people, and they would be forced into managed care plans instead.

Special Interest Exception for Union Members. One group would be able to avoid the punitive tax and any resulting health care rationing. The Mitchell bill exempts health insurance plans negotiated under labor union agreements. This is a blatant special-interest exception. If the global budget and associated tax are desirable for all other plans, they should be desirable for health plans that cover union members as well.

Rationing for Medicare Patients. To cover the additional costs of the overall legislation, the Mitchell bill proposes to cut Medicare spending by $278 billion over 10 years. This can be accomplished only by reducing Medicare patients' quality of and access to care.[13]

A Government-Defined Benefit Package

Under the Mitchell bill, the government would define a uniform health insurance benefit package. Initially, employers would be required to offer this package to their employees. After mandates are triggered, everyone would be required to buy it. The package would be formulated by a new federal bureaucracy called the National Health Benefits Board, similar to Clinton's National Health Board.

"After the mandate is triggered, everyone would be forced to have the package of insurance benefits chosen by government."

We will argue below that even without a mandate to purchase health insurance, the bill would effectively force most people who have insurance to purchase their insurance through a cooperative (or alliance) in which only the

standard benefit plan will be available.[14] Once the defined-benefit package becomes mandated, however, then all Americans will experience loss of freedom of choice and higher health care premiums. Let's see why.

Loss of Freedom of Choice. Everyone would be forced to buy the health insurance coverage chosen by the government — and influenced by powerful special interests — rather than the coverage that meets their individual and family needs. For example, all families would be forced to pay for abortion coverage, drug and alcohol rehabilitation, open-ended mental health benefits and counseling, and routine health services that might be cheaper if purchased directly rather than through insurance. While people could buy coverage for additional (supplemental) benefits, they could not replace benefits they did not want with others they did want in their basic health plan.

Higher Health Insurance Premiums. Unnecessary benefits impose unnecessary costs. For example, mandated drug and alcohol rehabilitation benefits at the state level raise premium costs by 6 to 8 percent.[15] Mandated state benefits for outpatient mental health services raise costs by 10 to 13 percent.[16]

An Invitation to Special Interests. Over time, special interests likely would add even more expensive benefits, as they have at the state level:[17]

- Thirty-seven states require health insurance coverage for the services of chiropractors, three states mandate coverage for acupuncture and two require coverage for naturopaths (who specialize in prescribing herbs).
- Laws in 40 states mandate coverage for alcoholism, 20 states mandate coverage for drug addiction and 30 states require coverage for mental illness.
- Five states even mandate coverage for in vitro fertilization.

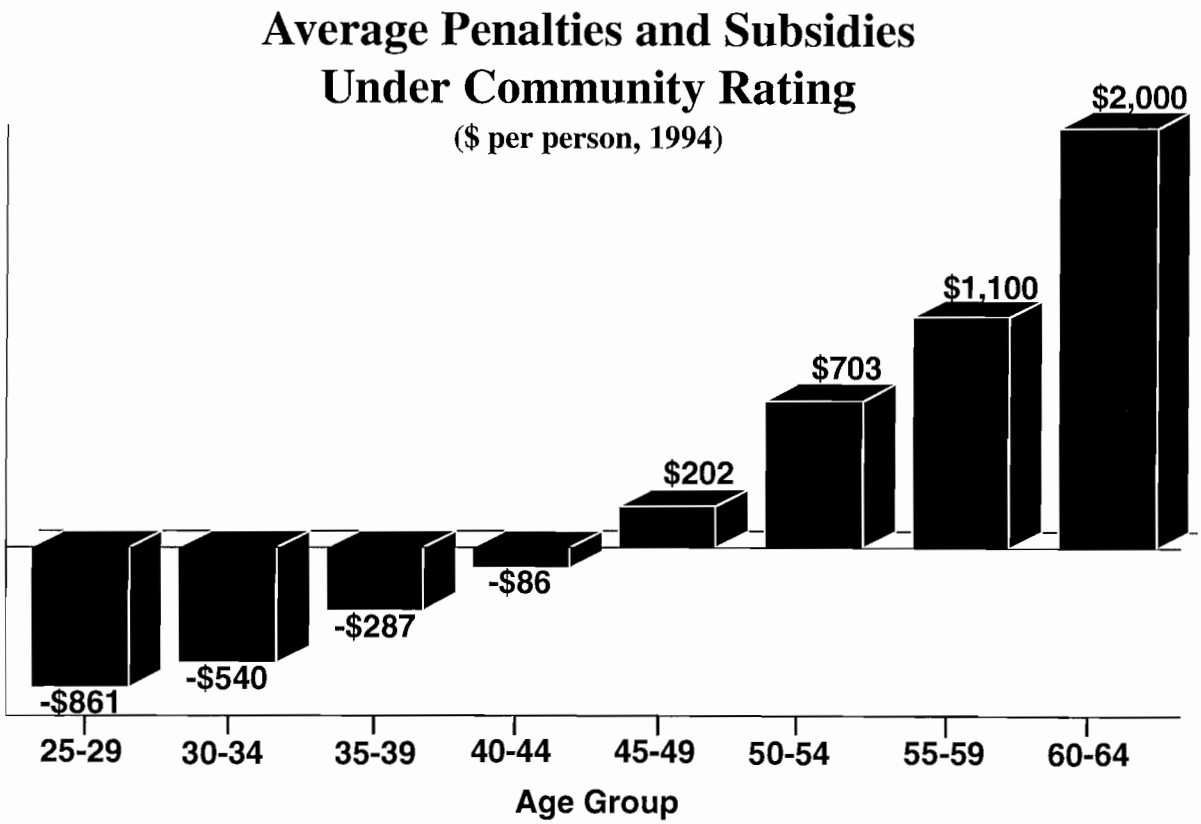
"Government-mandated benefits are an invitation to special interests."

Mandated benefits cover everything from life-prolonging procedures to purely cosmetic devices. They cover heart transplants in Georgia, liver transplants in Illinois and hairpieces in Minnesota. Collectively, these mandates have added considerably to the cost of health insurance, and they prevent people from buying no-frills insurance at a reasonable price.

Encouraging Waste. In addition, a mandated benefit package could add to the third-party-payment problem and its cost-increasing incentives. As insurance coverage for everybody is extended to more and more services, people are encouraged to overconsume these services and obtain wasteful, unnecessary care, because someone else is paying the bill.[18]

Eliminating the Search for Cost Control. In recent testimony before Congress,[19] Harvard Business School Professor Regina Herzlinger explained that the most important reason why the rate of increase in health care spending has been declining in recent years is that employers have been free to experi-

FIGURE I



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

ment with the design of their employee health insurance benefit packages. The ability to change benefits and the terms under which they are available has led to discoveries about which cost-control strategies work. A uniform benefit package would outlaw the search for solutions to our most serious national health care problem.[20]

Community Rating

"Younger people with lower incomes and fewer assets would pay more to subsidize older people with more income and assets."

Under the Mitchell bill, community rating would apply to all health insurance sold to individuals in groups of 500 or less. After the year 2000, premiums would be the same for everyone, regardless of health risk or condition. Until the year 2000, variations would be allowed only for family size, geography and age. As a result, a new health insurance applicant with AIDS or cancer could not be charged any more than an applicant who is healthy.

The Mitchell bill also includes guaranteed issue, which means insurers would be required to accept and cover all applicants regardless of health status or risk. As a result, those currently uninsurable would be able to buy insurance. Yet under community rating, they would pay only a small portion of the cost of their care, most of which would be paid through higher premiums for everyone else.

Under the Mitchell bill, community rating would be calculated on the basis of geographic areas with boundaries drawn by each state. Mitchell would prohibit the states from subdividing any metropolitan area, requiring everyone in each metropolitan area to be in the same community-rated pool. This would bring the high costs of central city areas to the suburbs. Health costs reflecting the higher cost of city living would be unfairly imposed on outlying areas, where incomes reflect lower general living costs.

Higher Premiums for Most People. As a result of community rating, younger and healthier people would have to pay artificially high premiums in order to cover the higher costs of older and sicker people. In general, expected health care costs for adults ages 60 to 64 are two to three times as high as for people 25 to 29. As a result, under pure community rating, premiums for people 25 through 29 would be 50 percent higher than otherwise, and people 26 through 34 would pay $26 billion more per year. As Figure I shows, almost everyone below their mid-40s would pay more under community rating.

"An applicant with AIDS or cancer could not be charged any more than a healthy applicant."

Penalizing Those Who Have Less to Subsidize Those Who Have More. While older employees would pay less under community rating, on average they have more income and assets than younger employees who would pay far more.

- The median income of people 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.[21]
- 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.[22]
- Those under 35 have substantially less than half of the assets of those ages 45 to 64.[23]

Thus community rating perversely redistributes income from those who have less to those who have more.

Pulling the Trigger: Increasing the Uninsured. Despite the fact that the Mitchell bill would initially offer generous subsidies to the uninsured in an attempt to induce them and their employers to purchase insurance voluntarily, it is possible that the number of uninsured would increase rather than decline. The reason is that the healthy would have an economic incentive to drop their insurance, knowing that they could buy insurance at standard community rates if they became sick. As low-cost healthy people dropped out, premium costs for those who remained would rise more, encouraging even more healthy people to drop their coverage.

The premium increases would preclude the attainment of 95 percent coverage by 2000. Thus the Mitchell bill would pull its own trigger for the employer and individual mandates.

Case Study: New York. In 1993, the state of New York implemented legislation requiring insurers to (1) accept all applicants regardless of health status and (2) charge everyone the same premium for health insurance. According to the New York Department of Insurance:

- In 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.

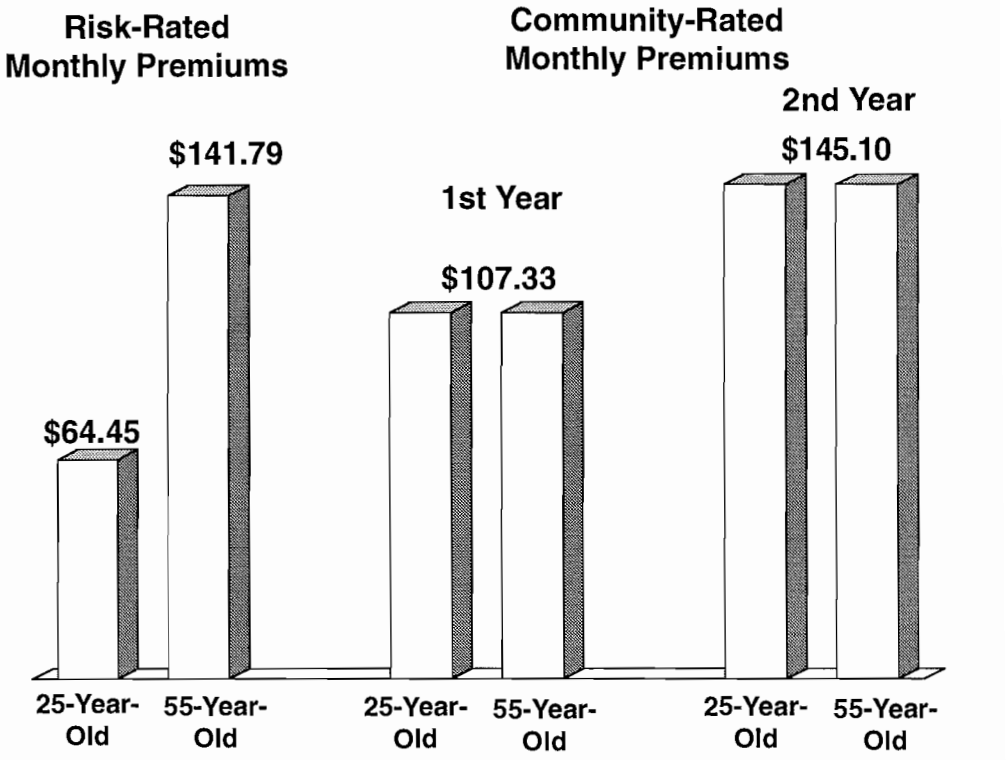
Consider the experience of Mutual of Omaha, the only major company besides Blue Cross selling individual policies in the state. Nationally, Mutual's claims (medical expenses paid under its policies) averaged about $3,800 per family last year, an increase of only $400 from 1992. But under community rating in New York, its average claim more than doubled, rising to $7,900. These increased claims resulted in a 35 percent increase in premiums, on top of a huge increase already adopted when community rating was implemented.

Before community rating was instituted in New York, 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.[24] After community rating, both paid

"After community rating was imposed in New York, one out of six people dropped their coverage."

FIGURE II

The New York Experience



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

$107.33, a 60 percent increase for the 25-year-old and a 32 percent decrease for the 55-year-old. This year, because of higher costs, both will pay $145.10 — more than the 55-year-old was paying *before* community rating was implemented. [See Figure II.] Thus even those who are initially helped by the program are made worse off as cost increases push up premiums.

In response to these premium increases, large numbers of New Yorkers have dropped their coverage and are taking the risk of going uninsured.

- The New York Department of Insurance estimates that about 44,000 individual policyholders have canceled their coverage since the law took effect,[25] but this estimate ignores the people who dropped their coverage in anticipation of the imposition of community rating.
- A new study by Mark Litow and Drew Davidoff for the actuarial firm Milliman and Roberston, Inc. estimates that 500,000 New Yorkers with individual and small group policies canceled their policies, reducing the number of insured from 2.8 million to 2.3 million.[26]

Alternatives To Community Rating: A Better Solution. Many mistakenly believe that the only alternative to community rating is experience rating. Under that approach, insurers reevaluate the health status of their 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 from high costs after they become sick. For example, a policyholder who gets cancer under experience rating could have sharply higher premiums the following year.

The solution is to replace community rating and guaranteed issue with guaranteed renewability and state uninsurable risk pools. Under guaranteed renewability, insurers would be prohibited from canceling coverage or raising rates after a policyholder got sick and would be required to renew coverage at the same rate for everyone with the same policy. However, applicants would be charged actuarially fair rates reflecting their present and future health risk at the time they joined a plan.

"Risk pools could cover the uninsurable for less than one-tenth of 1 percent of total health care spending."

For those who became sick and uninsurable while without coverage, each state could establish an uninsurable risk pool. Such pools would provide essential coverage in return for above-average premiums up to some reasonable limit, perhaps 25 or 50 percent more than standard rates. The premiums could be related to applicants' income and assets so that no one was excluded because of insufficient funds. Each state would then subsidize any deficit in its risk pool from general revenues — much fairer than the regressive taxes effectively imposed under the Mitchell bill, including taxes on cigarettes and cuts in the Medicaid and Medicare programs.[27]

Risk pools are already in operation in 28 states, covering about 100,000 people. 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 1 percent of the nation's annual health care bill.[28] 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.[29]

Health Insurance Purchasing Cooperatives

While Mitchell claims that his bill provides for voluntary health insurance purchasing cooperatives (HIPCs), his bill includes the following mandatory features:

- A HIPC must be established for each geographic area, either by the state or by the Federal Employees Health Benefit Plan (FEHBP).
- Each HIPC must cover an entire community rating area and include at least 250,000 people (although states may approve more than one HIPC for each area).
- Firms with fewer than 500 workers must offer their employees participation in a HIPC; if they also offer other plans, they must offer at least three, including a fee-for-service plan, a point-of-service plan (with different reimbursement rates for different providers) and an HMO.
- To qualify for employer contributions, workers must purchase insurance through the HIPC or one of these employer-chosen plans.
- Employer-provided insurance would be tax exempt, while other coverage would be only 50 percent deductible.

These provisions would push the majority of people into HIPCs. Under the original Clinton proposal, participation in HIPCs (or alliances) would have been mandatory. Like the four versions of the Clinton plan written by congressional committees, the Mitchell bill makes participation voluntary. But like the four committee bills, the Mitchell bill contains provisions that would make it difficult or impossible for a market for insurance to exist outside of alliances.

"Effectively, most people would be forced to choose an insurer through a purchasing alliance."

For example, insurers would be prohibited from selling coverage outside an alliance for a lower premium than inside an alliance. Moreover, plans outside of alliances — including experience-rated plans — would be subject to a risk adjustment mechanism under which state governments could tax plans with healthier enrollees to subsidize those with sicker enrollees. In

general, then, insurers would be unlikely to discover any advantage in selling insurance coverage outside alliances and most people would probably have no options outside of alliances.[30]

Managed Competition

The central idea behind the Clinton plan was managed competition.[31] The Mitchell bill promotes the same concept.

How Managed Competition Works. The objective of managed competition is to create an artificial market for health insurance in which individuals choose among competing health plans charging the same premium to every applicant.[32] Thus, among people entering or changing a health plan, a person who has AIDS would pay the same premium as someone who does not, and people in hospital cancer wards would pay the same premiums as people who do not have cancer. Because of this one-price-for-all rule, the premiums sick people pay would be well below the expected cost of their treatment, while the premiums of healthy people would be substantially higher. As a result, the incentives for the plans to avoid sick people and attract healthy ones would be far greater than under the current system.

Result: Lower-Quality Care for the Sick. Under managed competition, heart patients would tend to choose the plans with the best cardiologists and cancer patients the plans 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 switch plans if they became seriously ill. This would create extremely perverse incentives for health plan managers. *No plan could afford a reputation as the best for those with expensive-to-treat illnesses.* Indeed, the plans that attracted a disproportionate number of sick people would eventually fail. Moreover, each health plan would have an incentive to underprovide services to the sickest people and overprovide to the healthy.[33] Specifically:

"Health plans would have an incentive to lower the quality of care provided to sick people."

- The natural tendency of managed competition is to compete the amount health plans are willing to spend for the care of the sick down to the level of the premiums sick people pay.
- By contrast, there would be a natural tendency to compete the amount health plans are willing to spend on the healthy up to the level of the premiums healthy people pay.
- 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.

Result: An Absence of Fee-for-Service Plans. Some might seek to avoid low-quality medical care by choosing a fee-for-service plan. By definition such plans leave patients free to select physicians and physicians free to practice medicine in accordance with their consciences and skills. These freedoms would make it virtually impossible for fee-for-service plans to avoid the sick if they were in competition with HMOs. Since the fee-for-service plans are likely to attract sick people whose premiums are well below the cost of their medical care, the plans are unlikely to survive. Proponents of managed competition are well aware of this. For example, Representative Jim Cooper (D-TN), whose bill was considered the purest version of managed competition before Congress, said, "My guess is that fee-for-service medicine will be discouraged and mostly die out."[34]

Risk Adjustment. As health plans compete to attract the healthy and avoid the sick, some will be more successful than others. The most successful will be able to charge a lower (community-rated) premium, not because they have fewer services or are more efficient but because they have healthier enrollees.

Risk adjustment mechanisms are supposed to prevent this result.[35] They take funds from plans with healthier enrollees and subsidize plans with sicker enrollees. If they worked perfectly, health plans would be indifferent between a healthy applicant and a sick one. But they will not work for the following four reasons.

First, government bureaucrats have no way of determining the correct amount of income redistribution needed to offset the perverse regulatory incentives. If they merely reimbursed plans for the higher actual costs of treating sicker patients, they would eliminate any incentive to keep costs down. Even the CBO has said that the feasibility of developing and implementing such mechanisms in the near future is highly uncertain.[36]

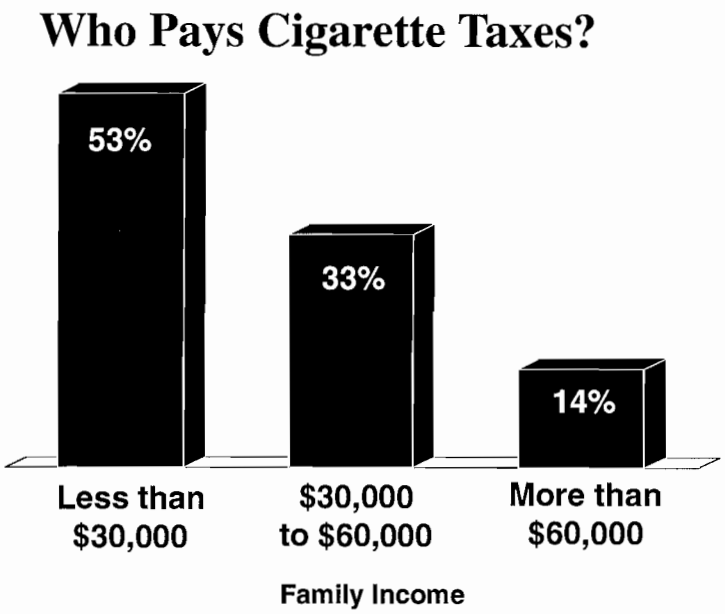
Second, as the CBO says of the Mitchell bill, "The risk-adjustment mechanism in this proposal is more complex than those in other proposals analyzed by the CBO. Most other proposals would restrict risk adjustment to the community-rated market; in Senator Mitchell's proposal, risk adjustment would operate in both the community-rated and the experience-rated markets in each community-rating area."[37] This means risk adjusters would have the power to "tax" the plans of firms with more than 500 employees even though their employees were not participating in the alliance. Presumably, even self-insured plans would be subject to such assessments.

"Fee-for-service plans, allowing choice of physicians, would be unable to survive."

Third, as a practical matter, no health plan is going to go all out to provide the best care for the sickest patients, building up huge losses as a result and counting on the government to cover its losses by redistributing funds to it from other health plans. Instead, health plans would have strong incentives to compete to avoid the sickest patients and, only if they could not, to look to risk-adjustment redistribution.

"The cigarette tax would fall disproportionately on lower-income families."

FIGURE III



Note: The figure shows the share of all cigarette taxes paid by different income groups.

Source: "Measuring the Impact of Increasing Excise Taxes on the Progressivity of the Federal Tax System," The Policy Economics Group, KPMG Peat Marwick, March 1993.

Finally, the risk-adjustment system would eventually give the risk adjusters complete control of health care. The reason is that health plans would deliver only the services and the care for which the risk adjusters reimbursed them.

Higher Taxes

Last year, Congress enacted a huge tax increase on the grounds that it was necessary to get the federal budget under control. This year, Senator Mitchell proposes another large tax increase that would fall mostly on the middle class, in order to finance one of the largest increases in government spending and entitlements in history. The new taxes in the Mitchell bill include:

- A 1.75 percent tax on all private health insurance premiums, including self-insured plans.
- A 25 percent global budget tax on the premiums of all health insurance plans if they exceeded global budget targets.
- Abolition of Flexible Spending Accounts, under which employees can use pretax dollars to pay medical expenses not covered by employer plans.[38]

- Extension of the Medicare hospital insurance tax to all state and local employees.[39]
- More than doubling the tax on cigarettes.[40]

Most of these taxes would fall primarily on the middle class. But two of the biggest revenue raisers — the tax on premiums and the higher tax on cigarettes — would create greater burdens for lower-income families. For example, the premium tax would tend to be the same for everyone, since the vast majority of people would be forced to accept the basic benefit package. But this tax as a percent of income would be higher for those earning less.

Since smoking varies inversely with income, the huge increase Mitchell proposes in the cigarette tax also would fall disproportionately on lower-income families. In fact, the cigarette tax is probably the most regressive of all federal taxes. [See Figure III.] According to CBO estimates, this increased cigarette levy would impose $56.5 billion in new taxes over the first 10 years.[41]

The new tax burden would total $28.9 billion in the year 2000, including the tobacco tax. In 2004, the middle-class tax increase would total $45.5 billion. Over the first 10 years, these tax increases would exact $255.3 billion from working men and women.[42]

Cost Shifting

Supporters of the Mitchell bill argue that despite the burdens the bill would create for middle-class families, the bill is still in their self-interest because those families would gain financially if fewer people were uninsured. When uninsured people don't pay their medical bills, they argue, those costs are shifted to the rest of us through higher medical bills and higher taxes. Thus if the uninsured had insurance, health care would be cheaper for everyone else.

"Cost shifting from Medicare and Medicaid would more than offset the reduction in uncompensated care for the uninsured."

What this argument ignores is that we also pay higher fees because Medicare and Medicaid do not pay the full cost of the services their beneficiaries receive, and the Mitchell bill proposes deep cuts in these two programs. As Figure III shows, the increase in cost shifting caused by cuts in Medicare and Medicaid funding would more than offset the reduction in unpaid bills caused by insuring the uninsured. On balance, *medical bills and insurance premiums for paying patients will go up, not down, as a result of Mitchell's health care reform.*

Reduction in Cost Shifting Caused by Patients Who Are Uninsured. Cost shifting occurs when one group of patients pays less than the true cost of their medical care. In order to stay solvent, providers cover these losses by overcharging everyone else. No one knows precisely how much cost shifting there is, and its magnitude is open to debate. The Congressional Budget Office (CBO) estimates that the uninsured pay only about 30 percent of the cost of the health care they get each year. As a result:[43]

- The CBO estimates that in 1991 the uninsured received about $15.2 billion in "uncompensated" hospital care and another $10.2 billion in "uncompensated" physician services.
- After making some adjustments, the CBO estimates that the uninsured caused $20.3 billion in costs to be shifted to paying patients.
- That figure is predicted to grow to $53 billion by the year 2003. [See Figure IV.]

Although the number may seem large, the amount of "free" care the uninsured get is only a small fraction of the nation's total health care bill — about 2.9 percent. Considering that bad debts for the economy as a whole are 2.5 percent of sales,[44] the number for the health care sector certainly does not suggest that we are facing a crisis.

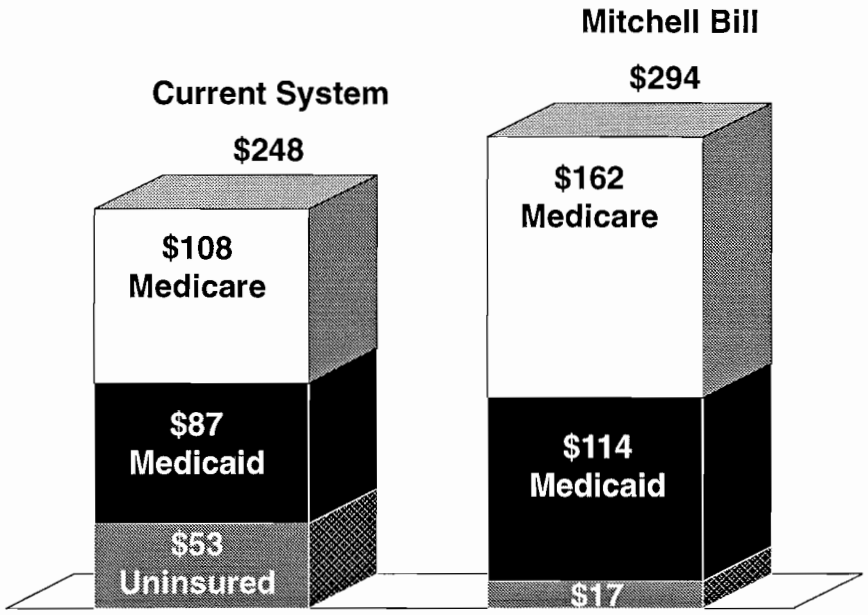
Increased Cost Shifting Caused by Medicare and Medicaid. Medicare and Medicaid routinely pay less than the real cost of the services their beneficiaries receive. Yet hospitals and doctors must either accept their rates or be excluded from the programs. This type of cost shifting is considerably larger than the cost of free care provided to the uninsured.

"Cost shifting would increase under the Mitchell bill — between $46 billion and $123 billion a year."

FIGURE IV

Cost Shifting Under the Mitchell Bill

($ billions; year 2003)



Note: The figure shows the underpayment of medical bills and health insurance premiums by Medicare, Medicaid and the uninsured.

Source: Calculations by Gary Robbins and Aldona Robbins, using the National Center for Policy Analysis/Fiscal Associates Health Care Model. (These estimates are static, and do not take into account the behavioral changes that would result from changed incentives.)

- According to the CBO, Medicare payments to hospitals and doctors are only 70 percent of private patient payments.[45]
- Medicaid payments to hospitals and doctors are 63 percent and 45 percent of private payments, respectively.[46]
- Thus the biggest sources of uncompensated care in our health care system are Medicare (33.0%) and Medicaid (42.6%), not unreimbursed care for the uninsured (24.3%).[47]

The Mitchell bill proposes to increase the gap between actual costs and reimbursements by $203 billion in Medicare alone over the next eight years. As a result:[48]

- Cost shifting from Medicare to private payers would increase by more than 50 percent.
- By the year 2000, the average medical bill would be at least 6 percent higher because of cost shifting from Medicare alone.

"Three-fourths of all cost shifting is caused by government."

The Medicaid population would be enrolled in private health insurance plans. Yet while Medicaid enrollees consume twice as much health care as other people, the government would not pay a higher premium. The CBO estimates that the Senate Finance Committee bill (one basis for the Mitchell bill) would increase premiums for individuals and small businesses by almost 13 percent, primarily because of cost shifting from Medicaid enrollees.[49]

Net Increase in Cost Shifting. The Mitchell bill attempts to solve a minor problem (reducing uncompensated care for the uninsured) by making a major problem (uncompensated care under government programs) even worse. Based on the CBO's assumptions about the magnitude of cost shifting, Gary Robbins and Aldona Robbins used the National Center for Policy Analysis/Fiscal Associates Health Care Model to estimate that:

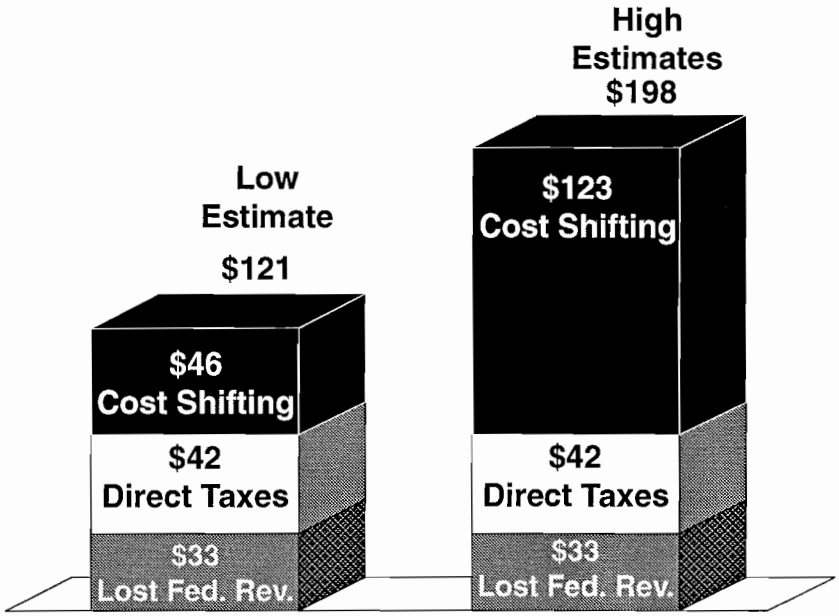
- Without health care reform, cost shifting would increase medical prices by about 11 percent in the year 2003, and uncompensated care for the uninsured would contribute about 2.4 percentage points to that amount.
- The total amount shifted at the end of the decade would be about $248 billion per year. [See Figure IV.]
- The Mitchell bill purports to reduce uncompensated care from $53 billion to $17 billion in the year 2003, but increased cost shifting from Medicare and Medicaid will more than offset that gain.
- Under the Mitchell bill, cost shifting would increase from $248 billion to $294 billion — even though the amount of uncompensated care for the uninsured will be dramatically lower.

"Overall, the Mitchell plan would cost up to $2,000 per year per U.S. household."

FIGURE V

Cost of the Mitchell Bill for Middle-Class Families

($ billions; year 2003)



Note: Cost shifting represents the underpayment of medical bills and health insurance premiums by Medicare, Medicaid and the uninsured in the year 2003. The loss estimate is based on Congressional Budget Office calculations. The high estimate assumes providers are unable to shift underpayment by Medicaid to other patients and shift only one-half the underpayment by Medicare and the uninsured. Lost federal revenue is due to reduced work by lower-income workers produced by higher effective marginal tax rates implicit in the Mitchell bill's subsidies for individuals.

Source: Calculations by Gary Robbins and Aldona Robbins, using the National Center for Policy Analysis/Fiscal Associates Health Care Model. (These estimates are static, and do not take into account the behavioral changes that would result from changed incentives).

Total Cost of the Mitchell Bill

"For every $1 in direct taxes, the plan has up to $4 in hidden costs."

Besides the direct cost from taxes and the indirect cost from cost shifting, the Mitchell bill will also exact a cost in lost federal revenue. Under the Mitchell bill, health insurance subsidies for low-income families are phased out at higher income levels in a way that would create extremely high effective marginal tax rates. Indeed, the CBO notes that some workers under this plan would get to keep only 15 cents out of an extra dollar of earnings.

These high marginal tax rates would lead to less work and less production, lowering national income by $65 billion in the year 2003. Even if we attribute this loss of income totally to those who reduce their work effort, the rest of society would still be worse off. That is because, with less national

income, government would collect about $33 billion less in taxes. And general taxpayers would have to make up this revenue shortfall.

Cost of the Mitchell Bill: Low Estimate. Assuming the CBO is correct about the ability of health providers to shift costs, the Robbinses estimate that:

- The Mitchell bill would increase costs for middle-class families by about $121 billion in the year 2003. [See Figure V.]
- This equals a cost of more than $1,000 per household per year.

Cost of the Mitchell Bill: High Estimate. Not all health economists agree with the CBO's assumptions about the ability of providers to shift costs. In a study produced for the American Enterprise Institute, Professor Michael Morrisey argues that there is very little cost shifting. When the government underpays for Medicare and Medicaid patients, Morrisey says, these patients tend to receive lower-quality (less costly) care. This argument is more persuasive with respect to Medicaid patients (who are limited in the doctors they can see and hospitals they can enter) than for Medicare.

Accordingly, Figure V also shows the cost of the Mitchell bill, assuming that providers are unable to shift Medicaid costs to paying patients and can shift only one-half the costs of Medicare and uninsured underpayments. Under this estimate:

- The total cost of the Mitchell bill for middle-class families in 2003 would be almost $200 billion.
- This equals almost $2,000 per household per year.

Higher Government Spending

The Mitchell bill proposes a blizzard of new government subsidies, benefits, programs, entitlements and government spending increases. In total, the proposal represents the largest increase in entitlements and government spending in history. The major new spending provisions include:

Subsidies for Individuals. The bill provides generous health insurance subsidies for individuals up to 200 percent of the poverty level, or about $32,000 for a family of four. For pregnant women and children, the subsidies climb to 300 percent of poverty, or close to $50,000 for a family of four. After an individual mandate is triggered, everyone — regardless of income level — apparently would be eligible for a subsidy to keep the employee's share of the premium to no more than 8 percent of income. The CBO estimates that these subsidies would climb to over $100 billion in total annual costs by 1999, and to $150 billion by 2004. From 1997 to 2004, the CBO estimates that these subsidies would cost $930 billion.[50]

"The Mitchell bill proposes a blizzard of new subsidies, benefits and entitlements."

Subsidies at these income levels are unjustified. When government subsidizes average and above-average income families, it is taking people's money from them and then returning it minus a service charge. Insurance subsidies should be limited to low-income families who otherwise would not be able to pay for essential health coverage. Subsidies might reasonably end at 150 percent of poverty, about $24,000 for a family of four, as proposed by Senator Bob Dole (R-KS).[51]

Business Subsidies. The Mitchell bill also subsidizes employers who expand coverage to all of their employees or to all in subgroups such as part-time employees. This subsidy is not targeted to the needy. All subsidies for the purchase of health insurance should be directed to the individuals themselves and be limited to those in need.

Home Health Care Services. The Mitchell bill introduces a new government program, so-called home health care services for the disabled. The services comprise not health care but assistance with basic activities, such as cooking, cleaning, bathing and dressing. Most such care is provided today by family and friends. Mitchell's proposed program would displace voluntary assistance with costly, taxpayer-financed professional care. Moreover, the government would be unable to monitor such personal services. Once government-financed housekeepers and cooks began working in a home, it would be administratively impossible to limit their services to the disabled recipient. Other family members would tend to benefit from the cooking, cleaning and housekeeping financed by the government.[52]

"The best estimate is that the home health care proposal would cost more than $30 billion per year."

Mitchell proposes an arbitrary spending cap of $48 billion over the period 1995 to 2004 for such benefits. But such a cap would be untenable. Based on studies of previous proposals, home health care services would cost more than $30 billion per year.[53] Such new spending is unnecessary and unwise. Under Medicaid, government already finances home health care for those who would otherwise be in more expensive nursing homes at government expense.

Prescription Drugs. Mitchell further proposes to expand Medicare benefits for prescription drugs, at a cost of about $100 billion over the first six years and $278 billion over 10 years. The new spending would add to Medicare's huge long-term financial crisis.[54] Yet Mitchell completely ignores this intractable problem and proposes to largely fund his overall legislation — including the new Medicare benefits — through major reductions in Medicare spending. Such Medicare reductions could not occur without massive cost shifting by hospitals and doctors to non-Medicare patients or, what is more likely, severe rationing of health care for the elderly with Medicare benefits.

Other Increased Spending. The Mitchell bill includes numerous other new spending initiatives as well. The CBO estimates that these would cost over $30 billion per year by 2000 and almost $45 billion per year by 2004. From 1997 to 2004, these provisions would raise spending by $290 billion.[55] These initiatives include insurance subsidies for the unemployed, enrollment outreach for the uninsured, academic health centers, school clinics and the revival of other public health programs.

No Medical Savings Accounts

The root cause of rapidly rising health care costs is third-party payment of medical bills. In health care, someone other than the consumer is usually paying the bills — whether an insurance company, employer 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, and doctors and hospitals compete almost exclusively to maximize quality. The Mitchell bill would escalate this problem in several ways:

- It would extend third-party coverage to all of the uninsured.
- It would force everyone to buy a standard government benefit package covering services for which many or most workers do not have coverage today.
- It would force everyone to buy insurance with low deductibles and copayments.

The way to counter this problem and expand coverage is to adopt Medical Savings Accounts (MSAs).[56] MSAs are designed to reverse the third-party payment incentives described above. With an MSA option, instead of paying all of their health care dollars to the insurance company, employers and employees would buy a catastrophic policy with a high deductible, perhaps $3,000 per year. The rest of the funds, traditionally allotted to insurance, would be paid into an MSA for each worker. The worker would pay for health care expenses below the deductible with MSA funds. 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 unspent MSA funds into an IRA or other tax-exempt savings fund at retirement.

"Medical Savings Accounts are a proven way of controlling health care costs."

Paying routine health expenses out of their own MSA funds, employees would have strong incentives to control costs, and doctors and hospitals would compete by reducing costs while improving quality. This MSA concept has been tried by several large employers, with great success and acceptance.[57]

However, Mitchell's bill does not include MSAs, even though they are included in Senator Dole's bill and are probably supported by most senators. As a result, Mitchell fails to address the root cause of rapidly rising health costs and his bill would exacerbate that problem. The only significant tool in his bill to cost control is health care rationing that would be brought about through the global budget tax.

Conclusion

While Mitchell has proclaimed his bill new and different, it includes all the major features of President Clinton's proposal — plus even higher taxes and even more government spending. Contrary to the rhetoric of Mitchell and his supporters, if the plan were adopted the big losers would be the middle class and the elderly.

"The middle class has the most to lose."

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] The Mitchell bill provides for a new federal bureaucracy called the National Health Care Cost and Coverage Commission that would recommend legislation by May 15, 2000 to achieve universal coverage in those states that had not achieved 95 percent coverage at the start of 2000. If Congress did not enact the commission's proposals, the employer and individual mandates described above automatically would go into effect.

[2] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured," EBRI Special Report, January 1994.

[3] See "Is Hawaii a Model for Health Care Reform?" National Center for Policy Analysis, NCPA Brief Analysis No. 126, August 19, 1994; and General Accounting Office, "Health Care in Hawaii: Implications for Reform," GAO/HEHS-94-68, February 1994.

[4] The CBO concluded that it could analyze the bill only by assuming the mandate applied in all states. See Congressional Budget Office, "A Preliminary Analysis of Senator Mitchell's Health Proposal," August 9, 1994, p. 14.

[5] See Peter J. Ferrara, "The Health Policy Debate: Options for Reform," National Center for Policy Analysis, NCPA Policy Backgrounder No. 131, July 7, 1994, pp. 2-7; and "Why Employer Mandates Hurt Workers," National Center for Policy Analysis, NCPA Brief Analysis No. 110, June 27, 1994.

[6] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," p. 3.

[7] See Peter J. Ferrara et al, "The Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 174, May 1994, pp. 38-40; and Ferrara, "The Health Policy Debate," pp. 2-5.

[8] At the low end, the administration admits that some 600,000 jobs might be lost in the early years, while economists Lawrence Hunter and Morgan Reynolds estimate 1,151,000 jobs would be lost and labor economists June and David O'Neill estimate the elimination of 2.1 million jobs. See Ferrara et al., "The Clinton Health Plan," pp. 38-40; and Ferrara, "The Health Policy Debate," pp. 2-5. Economists Aldona Robbins and Gary Robbins expect 783,000 fewer jobs under the Clinton plan. See Aldona Robbins and Gary Robbins, "Forecasting the Effects of the Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 185, May 1994.

[9] For further discussion of mandates, see Ferrara, "The Health Policy Debate," pp. 2-7.

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

[11] 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.

[12] 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.

[13] For further discussions of global budgets, see Ferrara, "The Health Policy Debate," pp. 22-27; and Ferrara et al., "The Clinton Health Plan," pp. 7-11.

[14] The purpose of alliances is to impose managed competition on the health care system, and advocates of managed competition are virtually unanimous in the belief that all insurers should be forced to offer a uniform benefit package and no other. Thus although the bill does not outlaw other benefit packages, it is likely that alliances in practice will not allow them.

[15] Ferrara, "The Health Policy Debate," p. 9; and Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits,"*Inquiry*, Vol. 26, No. 4, Winter, 1989.

[16] Ibid.

[17] 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; see also Greg Scandlen, "State-Mandated Coverage: Mandate Evaluation Laws," Blue Cross/Blue Shield, Office of Government Relations, Washington, DC, August 13, 1990.

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

[19] The Republican Members of the Joint Economic Committee and the House Republican Research Committee's joint hearing on "Health Care Reform That Works," August 9, 1994.

[20] For further discussion of the problems of such a uniform, government-defined benefit package, see Ferrara, "The Health

Policy Debate," pp. 7-9.

[21] "Money Income of Households — Percent Distribution by Income Level for Selected Characteristics: 1991,"*Statistical Abstract of the United States,* 1993, Table No. 713, p. 458.

[22] Ibid.

[23] *Changing Times*, March 1990.

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

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

[26] Mark E. Litow and Drew S. Davidoff, "The Impact of Guaranteed Issue and Community Rating in the State of New York," Milliman and Robertson, Inc., August 18, 1994.

[27] Even if the risk pools were funded by a tax on all health insurance premiums in a state (the most common method of funding current risk pools), such a tax would be much lower for low-income families.

[28] Karl J. Knable, Morris Melloy and C. Keith Powell, "State Health Insurance Risk Pools,"*Health Section News,* April 1991; Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High Risk Individuals: A State-by-State Analysis," June 1994. For further discussion of risk pools, see Ferrara, "The Health Policy Debate," pp. 33-35; and "Risk Pools: A Better Solution for Preexisting Conditions," National Center for Policy Analysis, NCPA Brief Analysis No. 112, June 30, 1994.

[29] Agency for Health Care Policy and Research, U.S. Public Health Service, U.S. Department of Health and Human Services, Washington, DC.

[30] For further discussion of such purchasing cooperatives and the best policies regarding them, see Ferrara, "The Health Policy Debate," pp. 25-26.

[31] The following section is based on John C. Goodman and Gerald L. Musgrave, "Primer on Managed Competition," National Center for Policy Analysis, NCPA Policy Report No. 183, April 1994. See also "Managed Competition: Hazardous to Your Health," National Center for Policy Analysis, NCPA Brief Analysis No. 117, July 22, 1994; Ferrara "The Health Policy Debate," pp. 13-25; and Ferrara et al., "The Clinton Health Plan," pp. 14-17 and pp. 33-76.

[32] For the theory behind managed competition and the general policy proposals made by its advocates, see Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*(Reading, MA: Addison-Wesley, 1980); Alain C. Enthoven, "The History and Principles of Managed Competition,"*Health Affairs* (Supplement 1993), pp. 24-48; and Alain C. Enthoven, Paul M. Ellwood and Lynn Etheridge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics* 1, 1992.

[33] Note that this problem arises only because of price controls created by community rating. Health plans would have no reason to avoid applicants if each person who enters an insurance pool pays a premium that reflects the expected cost and risk the person adds to the pool. See 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 Reforms: Competition and Controls* (Washington, DC: American Enterprise Institute Press, 1993), p. 155 ff.

[34] Alain Enthoven, the father of managed competition, has also been quoted as saying: "We doubt that (private practice doctors) would generally be compatible with economic efficiency. We would expect this type of practice to continue, but to decline gradually in importance." See John Merline, "Can Dr. Marcus Welby Survive? Or Will Health Care Reform Kill Private Practice?" *Investor's Business Daily,* October 6, 1993.

[35] See the discussion in Joseph Newhouse, "Rate Adjusters for Medicare Under Capitation,"*Health Care Financing Review* (1986 Annual Supplement), pp. 45-56, cited in Enthoven, "The History and Principles of Managed Competition," pp. 33-34; Michael Moore, "Risk Adjustment Under Managed Competition," Jackson Hole draft discussion paper, March 1993; and Wynand P.M.M. Van de Ven and René C.J.A. Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market?" in P. Ziveifel and H. E. Frech III, eds.,*Health Economics Worldwide* (Dordrecht, Netherlands: Kluwer Academic Publishers, 1992), pp. 23-46 and pp. 29-30.

[36] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," p. 7.

[37] Ibid. pp. 7-8.

[38] For a discussion of Flexible Spending Accounts and their treatment under the tax law, see Alain C. Enthoven, "Health Policy Mismatch," *Health Affairs,* Winter 1985, pp. 5-13.

[39] The tax rate is 2.9 percent, split between employer and employee, on all wage income. State and local employees were originally exempt from Medicare. In 1983, all new state and local employees were required to join the system.

[40] The current tax on cigarettes is 24 cents a pack. The Mitchell bill would increase the tax to 69 cents per pack.

[41] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Table 2.

[42] Ibid.

[43] Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," CBO Staff Memorandum, April 1993, p. 13.

[44] U.S. Commerce Department, National Income and Products Accounts, August 1994.

[45] CBO, "Single-Payer and All-Payer Insurance Systems Using Medicare's Health Payment Rates," pp. 7-8.

[46] Ibid.

[47] "Is Universal Coverage in Everyone's Self-Interest?" National Center for Policy Analysis, Brief Analysis No. 124, August 16, 1994.

[48] "How Much Will the Mitchell Bill Really Cost?" National Center for Policy Analysis, NCPA Brief Analysis No. 127, August 23, 1994.

[49] Ibid.

[50] Ibid. Table 2.

[51] See Peter J. Ferrara, "Evaluating Senator Dole's Health Care Plan," National Center for Policy Analysis, NCPA Policy Backgrounder No. 132, August 10, 1994.

[52] For further discussion of these home health care issues, see Peter J. Ferrara, "Long-Term Care: Why a New Entitlement Program Would Be Wrong," Cato Policy Analysis No. 144, December 13, 1990; Peter J. Ferrara, "Pepper's $30 Billion Home Care Time Bomb," Heritage Foundation Issue Bulletin No. 141, June 7, 1988; and Peter J. Ferrara, "Expanding Autonomy of the Elderly in Home Health Care Programs," *New England Law Review,* Vol. 25, 1990, pp. 421 ff.

[53] See Ferrara, "Pepper's $30 Billion Home Care Time Bomb."

[54] CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," Table 2.

[55] Ibid.

[56] For further discussions 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, 1993; and John C. Goodman and Gerald L. Musgrave, "The Economic Case for Medical Savings Accounts," paper presented at the American Enterprise Institute, April 18, 1994.

[57] See "Medical Savings Accounts: The Private Sector Already Has Them," National Center for Policy Analysis, NCPA Brief Analysis No. 105, April 20, 1994; and Ferrara, "The Health Policy Debate," pp. 28-30.

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