POLICY BACKGROUNDER No. 149
For people with limited time and a need to know.

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Reforming the U.S. Health Care System

Unwise government policies are largely responsible for the fact that the number of Americans without health insurance is 43 million and rising. Unwise government policies also are responsible for the fact that people who have health insurance are turning over an ever-larger share of their health care dollars to managed care bureaucracies that limit patient choices and sometimes give providers perverse incentives to deny care.

The proposals below would fundamentally alter the federal government policies that contribute to these problems. The proposals would eliminate distorted incentives, empower individuals and create new options in the health insurance marketplace.

"Unwise government policies are causing the number of people without health insurance to rise."

The proposals do not increase the financial role of government. Through tax subsidies and direct spending programs, federal and state governments already spend more than enough on health care and health insurance. Instead, the proposals would radically reorder government programs — to make them efficient and fair.

In constructing this document, we have benefited from many discussions with health policy analysts at other think tanks; representatives from industry, the medical community and government; and members of Congress and their staffs.

However, the proposals that follow are our own and we bear full responsibility for them.

I. UNIVERSAL COVERAGE

A. MAKING A COMMITMENT TO EVERY AMERICAN

1. This plan builds on current policy in recognizing that whether or not people have health insurance is a national issue in which the federal government has a legitimate interest.

2. But this is the first plan that precisely defines the federal government's financial interest and provides a vehicle for honoring the federal commitment, regardless of the choices made by the individual citizen.

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3. Under the plan, the federal government commits a fixed sum of money for health insurance for every American (say, $800 per adult and $2,400 for a family of four); the commitment is the same for everyone — rich or poor, black or white, male or female.

"Under this plan the federal government would make a financial commitment to every American."

B. ENCOURAGING EVERYONE TO PURCHASE PRIVATE HEALTH INSURANCE

1. Everyone who purchases private health insurance will be rewarded with a reduction in income taxes through a refundable health insurance tax credit.

2. The credit will consist of a dollar-for-dollar reduction in income taxes for health costs up to a maximum amount (e.g., $2,400 for a family of four).

3. Since the credit is fully refundable, even those who owe no income taxes will get the same financial help.

4. In most cases, employees will get the same tax relief if they obtain insurance through an employer, but employer plans can only qualify for one type of tax subsidy — either the tax credit system or the current system of excluding employer payments from employee taxable income.

C. KEEPING THE FEDERAL ROLE PURELY FINANCIAL AND LETTING PRIVATE HEALTH INSURANCE BENEFITS BE DETERMINED BY INDIVIDUAL CHOICE, COMPETITIVE MARKETS AND STATE REGULATIONS

1. This plan is not designed to subsidize the full cost of health insurance for an average family; in most places, federal tax relief probably will fund only a core benefits package with a very high deductible.

2. Individuals and their employers will be free to purchase more complete benefit packages, but they will pay the difference with aftertax (unsubsidized) dollars.

3. State governments will regulate the terms and conditions under which private insurance is bought and sold, just as they do now.

D. ENSURING THAT THOSE WHO ELECT TO REMAIN UNINSURED WILL HAVE ACCESS TO A SOCIAL SAFETY NET WITH A GUARANTEED MINIMUM LEVEL OF FUNDING

1. The tax subsidy will encourage the purchase of private insurance — those who obtain insurance will have more aftertax income.

"Those who purchase private health insurance would receive a tax credit."

2. The flip side of a tax subsidy is a tax penalty — those who fail to buy private insurance will pay higher taxes.
3. But unlike the current system under which higher taxes paid by the uninsured simply become part of the Treasury Department's general revenues, the "tax penalties" paid under this plan will be sent to state and local governments to fund health care for the uninsured.

II. A HEALTH CARE SAFETY NET FOR THE UNINSURED

A. KEEPING THE DECISION TO PURCHASE INSURANCE VOLUNTARY

1. No one will be forced to purchase private health insurance.
2. But those who elect to remain uninsured will have to rely on a local Health Care Safety Net if they cannot pay their medical bills from their own resources.

B. MAKING A FEDERAL COMMITMENT TO A HEALTH SAFETY NET FOR EVERY PERSON WHO ELECTS TO REMAIN UNINSURED

1. A family of four that is uninsured will pay higher taxes ($2,400) because of that fact.
2. The tax penalty will be rebated to state and local governments for local Health Care Safety Nets.

C. GIVING STATES AND LOCALITIES FULL DISCRETION OVER SAFETY NETS

1. Federal money for local Health Care Safety Nets will be like a block grant with one condition: the money must be spent on indigent health care.
2. However, no uninsured person will have the right to demand a particular health care service from the Safety Net.
3. Local authorities will be free to charge fees to the uninsured — especially if it appears that their lack of insurance is willful.

D. ACCEPTING THE REALITY THAT SAFETY NET SERVICES MAY NOT BE AS DESIRABLE AS SERVICES PROVIDED BY PRIVATE INSURANCE

1. Although the commitment of federal dollars to the two alternatives (private insurance or Safety Nets) is the same, the amount of money per capita available to local Safety Nets is expected to be less than the resources available through private insurance.

2. Thus, Safety Net doctors may not always be the very best doctors.

3. Safety Net programs may not be able to meet every health care need, and there may be some waiting.

4. These features are consistent with the overall goal of creating some form of universal coverage while at the same time encouraging private rather than public provision of health care.

E. ALLOWING LOCAL HEALTH CARE SAFETY NETS TO BE PARTLY OR EVEN FULLY FUNDED WITH FEDERAL HEALTH DOLLARS CURRENTLY GOING TO THE STATES

"For those who elect to remain uninsured, the unclaimed tax credit would help fund a local health care safety net."

1. This plan contains a rational mechanism for distributing federal health dollars to the states — i.e., states will receive more federal money if their uninsured population expands and less money if it contracts.

2. Under the current system, there is no necessary relationship between the amount of federal funding and any objective measure of need.

3. Under this plan, the federal government can discharge its commitment to the states by counting against that commitment dollars in current programs that fund indigent health care, provided that states gain full freedom and flexibility to use those funds to meet the needs of the uninsured.

F. USING SAFETY NET DOLLARS TO FUND HIGH-RISK POOLS

1. Under current law, states must create opportunities for certain uninsurable individuals — those who were previously insured — to obtain health insurance; and many have satisfied this obligation by creating high-risk pools.

2. This plan will encourage the expansion of such risk pools by allowing Safety Net money to fund them.

III. TAX FAIRNESS

A. PROVIDING, FOR THE FIRST TIME, JUST AS MUCH TAX RELIEF TO INDIVIDUALS WHO PURCHASE THEIR OWN HEALTH INSURANCE AS IS PROVIDED TO EMPLOYER-SPONSORED PLANS

1. Under the current system, employer payments for health insurance are excluded from the employee's taxable income — cutting the cost of health insurance in half for some middle-income families.

2. By contrast, individuals who purchase their own health insurance must do so with aftertax dollars — forcing some people to earn twice as much before taxes in order to purchase the same insurance.

3. This plan will provide the same tax relief to every taxpayer — regardless of how the insurance is purchased.

B. PROVIDING, FOR THE FIRST TIME, JUST AS MUCH TAX RELIEF TO LOW- AND MODERATE-INCOME FAMILIES AS IS PROVIDED TO HIGH-INCOME FAMILIES

"Low-income families would receive just as much tax relief as high-income families."

1. Under the current tax exclusion system, those in the highest tax brackets get the most tax subsidy for employer-provided health insurance — the top 20 percent of families get six times as much help from the federal government as the bottom fifth.

2. Under this plan, every family will get the same tax relief — regardless of the family's personal income tax bracket.

IV. A RATIONAL ROLE FOR EMPLOYERS

A. PUTTING EMPLOYER-PURCHASED INSURANCE AND INDIVIDUALLY PURCHASED INSURANCE ON A LEVEL PLAYING FIELD UNDER THE TAX LAW

1. For those who obtain insurance under the tax credit system, amounts spent by the employer on health insurance will be included in the employees' taxable income.

2. However, employees will receive a tax credit on their personal income tax returns.

3. This will be the same tax credit available to people who purchase their own insurance.

4. In this way, people will get the same tax relief for the purchase of private health insurance, regardless of how it is purchased.

B. ALLOWING THE EMPLOYER'S ROLE TO BE DETERMINED IN THE MARKETPLACE, RATHER THAN BY TAX LAW

1. Some health reform plans would require employers to provide health insurance; other plans would force employers out of the health insurance business.

2. This plan allows the market to determine the employer's role: if employers have a comparative advantage in organizing the purchase of insurance for their employees, competition for labor will force them into that role; if employers have no special advantage, they will avoid that role.

V. PRESERVING EMPLOYER OPTIONS, BUT REWARDING GOOD CHOICES

A. GIVING ALL EMPLOYERS THE OPTION OF KEEPING THEIR EMPLOYEES IN THE CURRENT TAX REGIME

"People who purchase their own insurance would receive just as much tax relief as people who obtain insurance through an employer."

1. Because many employers and their employees have made plans and organized their financial affairs around the current tax law, an abrupt change to the new system could be unfair.
2. Accordingly, employers will be given the option to keep their employees in the current tax exclusion system.
3. However, most employers will have an economic incentive to switch to the tax credit system because that will allow them to cut waste and inefficiency out of their health care plans without losing tax benefits.

B. REWARDING EMPLOYERS WHO HELP THEIR LOW-INCOME EMPLOYEES

1. Because the current tax exclusion system rewards those in the highest tax bracket the most, the system favors high-income employees.
2. But because the tax credit system treats all taxpayers equally, switching to it will help almost all low- and moderate-income employees.

"Employees could choose an alternative to their employer's plan; but employers would not be required to reimburse them."

3. Under the new plan, employers who help their low-income employees by switching to a tax credit regime, even though their higher-income employees may pay higher taxes as a result, will be rewarded: the new tax regime will lower the cost of their compensation packages and make it easier for them to compete for employees in the labor market.

VI. INCENTIVES TO REDUCE WASTE AND INEFFICIENCY

A. GIVING EMPLOYERS AND EMPLOYEES NEW OPPORTUNITIES TO REDUCE HEALTH CARE COSTS

1. Under the tax exclusion system, employees can reduce their tax liability by choosing (through their employers) more expensive health insurance plans.
2. In this way, the federal tax system encourages overinsurance and waste: An employee in a 50 percent tax bracket (including state and local taxes) will tend to prefer a dollar's worth of health insurance to a dollar of wages even if the health insurance has a value of only 51 cents.
3. By contrast, under the tax credit system no one will be able to reduce his or her taxes by purchasing more expensive health insurance.

4. Since marginal improvements in a health benefits package under the tax credit system can be purchased only with aftertax dollars, no one will spend an extra dollar on health insurance unless it produces a dollar's worth of value.

B. ALLOWING EMPLOYEES TO MANAGE SOME OF THEIR OWN HEALTH CARE DOLLARS

"Everyone could contribute to a Roth MSA — to pay medical bills not paid by insurance."

1. Current tax law rewards employees who turn over all their health care dollars to an employer health plan (by excluding such money from taxable income), but penalizes (by taxing) income placed in a Medical Savings Account; the exception is the pilot MSA program for the self-employed and employees of small businesses.

2. As a result, current law favors the HMO approach — in which the health plan controls all the health care dollars and makes all the important decisions — even though individuals might in many cases be better managers of their own health care money.

3. Under the new plan, individuals who choose the tax credit option will be able to deposit a certain amount of aftertax income — say, $2,000 per adult with a $5,000 family maximum — into a Roth MSA.

4. Contributions to Roth MSAs will be allowed only for individuals who have at least catastrophic insurance.

5. A Roth MSA is a "wraparound" account, designed to fund the purchase of any medical expense not covered by a health plan; it can be used in conjunction with an HMO as well as fee-for-service insurance.

6. Funds in a Roth MSA may be used only for medical care or must remain in the account to back up a health plan for at least one year.

7. At the end of the one-year insurance period, Roth MSA funds may be withdrawn without penalty for any purpose, left in the account to grow tax free or rolled over into a Roth IRA.

C. PUTTING THIRD-PARTY INSURANCE AND INDIVIDUAL SELF-INSURANCE ON A LEVEL PLAYING FIELD UNDER THE TAX LAW

1. The Roth MSA option will correct the bias in the current tax law.

2. Beyond a basic level of insurance, funded by the tax credit, individuals will choose to spend their aftertax dollars on more insurance benefits or place those same dollars in a Roth MSA.

3. Under this plan, no one will have an incentive to turn over additional dollars to a health plan unless they judge that the extra benefits they are purchasing are more valuable than the value of depositing an equal amount in a Roth MSA.

D. ENDING INCENTIVES TO OVERCONSUME THROUGH FLEXIBLE SPENDING ACCOUNTS

1. Just as the tax exclusion for employer-provided health insurance encourages people to overinsure, the current system of Flexible Spending Accounts (FSAs) encourages people to overconsume.

"Employers would have an option: stay in the current system or switch to the tax credit system."

2. Under the system, employees make pre-tax deposits to an FSA to pay their share of premiums and to purchase services not covered by the employers' health plan.

3. A use-it-or-lose-it rule requires that employees spend the entire sum or forfeit any year-end balance in the account.

4. This rule encourages wasteful spending on medical care at year-end.

5. Under the new plan, employees who are in the tax credit system will no longer have an FSA option.

6. Instead, they will have a use-it-or-save-it Roth MSA option.

VII. OPTIONS FOR THE SELF-EMPLOYED

A. GIVING THE SELF-EMPLOYED A NEW OPTION: A TAX DEDUCTION FOR THE PURCHASE OF HEALTH INSURANCE OR A TAX CREDIT

1. Currently, the self-employed get a partial deduction for the purchase of health insurance, and eventually they will get a 100 percent deduction.

2. As an alternative, this plan allows the self-employed to take a tax credit.

B. ALLOWING THE SELF-EMPLOYED WHO CLAIM A TAX CREDIT TO MAKE ROTH MSA CONTRIBUTIONS

1. Under the current system, the self-employed may contribute to a conventional MSA, provided they have catastrophic insurance.

2. Under this plan, the self-employed who elect the tax credit will be able to make deposits to a Roth MSA instead.

3. They will be allowed to contribute to either a conventional MSA or a Roth MSA, but not both during the insurance period.

VIII. SOLUTION TO THE SPECIAL PROBLEMS OF THE UNINSURED

A. SOLVING THE CASH FLOW PROBLEM FOR PEOPLE WHO PURCHASE THEIR OWN INSURANCE

"Because the tax credit is refundable, it would be available even to families that do not pay income taxes."

1. A refundable tax credit for the purchase of health insurance previously in the tax code failed because it did not address the cash flow problems of low-income families; it forced these families to rely on their own resources to meet premium payments for the year and wait for reimbursement until the following April 15.
2. As a result, the program did not make funds available for the purchase of insurance at the time the funds were needed.
3. This plan solves the problem for individually purchased insurance by allowing people to assign their rights to the credit to an insurance company month-by-month.
4. The procedure will be similar to the one under which low-income families can assign their right to collect the Earned Income Tax Credit (EITC) to a firm such as H&R Block in return for an immediate cash payment.
5. In this way, individuals will be able to buy health insurance without reducing in their monthly income.
6. This plan also will allow the health insurance tax credit to be combined with the Earned Income Tax Credit (EITC), so that families can afford a more generous package of benefits without lowering their monthly income.

B. SOLVING THE CASH FLOW PROBLEM FOR PEOPLE WHO OBTAIN INSURANCE THROUGH AN EMPLOYER

1. Most people who are uninsured are working, and many have the opportunity to join an employer plan but decline to do so.
2. One reason they decline is that they are required to pay a substantial part of the premium; some join themselves but do not insure their dependents.
3. This plan solves the problem, using a procedure similar to the one described above.
4. Currently, low-income employees who qualify for the EITC can file a form with their employer and receive their EITC "refunds" month by month.
5. In a similar way, the health insurance tax credit can be accessed month by month and used to pay the employee's share of the premium.

"The temporarily uninsured could use their tax credit to obtain insurance for part of a year."

6. Thus low-income employees can insure themselves and their families with no reduction in take-home pay; where options exist, the employees can also combine the health insurance tax credit with their EITC refund to obtain more generous coverage — again, with no reduction in take-home pay.

7. Employers will not be required to opt into the tax credit system, but those who do will be able to offer their employees a more attractive compensation package and gain a competitive edge in the labor market.

C. SOLVING THE PROBLEMS OF THE TEMPORARILY UNINSURED

1. Most people who are uninsured are temporarily uninsured — usually for a period of less than one year.

2. To meet the needs of these people, health reform must make a refundable health insurance tax credit flexible enough to fund health insurance coverage for part of a year.

3. The techniques described above will allow low-income employees to pay premiums month by month or even pay period by pay period.

IX. HEALTH INSURANCE AND WORKFARE

A. MAKING WORKFARE WORK

1. For many families, one of the biggest obstacles to getting and staying off welfare is the lack of a private insurance alternative to Medicaid.

2. This plan makes it possible for low-income families to buy into an employer health plan or to purchase insurance on their own.

B. BRIDGING THE GAP BETWEEN EMPLOYER-PROVIDED INSURANCE IN DIFFERENT JOBS

1. A related problem concerns people who are laid off or are temporarily unemployed while they are between jobs.

2. Periods of unemployment are typically periods when family financial resources are very limited.

3. The refundable health insurance tax credit can bridge the gap, financing the purchase of short-term insurance or funding COBRA payments that continue coverage under a previous employer's plan.

4. Funds in a Roth MSA also can help solve the problem, since such funds can be used to pay premiums during periods of temporary unemployment.

X. THE ROLE OF STATE AND LOCAL GOVERNMENTS

A. DEFINING OF STATE AND LOCAL GOVERNMENT ROLES

1. This is the first plan that defines the roles of state and local governments in meeting the needs of the uninsured.
2. By keeping the federal role purely financial, which largely continues current practice, the plan makes state governments responsible for regulating the terms and conditions under which health insurance will be bought and sold.

"Enabling people to buy private insurance will help make welfare reform work."

3. However, the plan retains the ERISA preemption which exempts from state regulation companies that self-insure because such companies are not purchasing insurance in the marketplace and because self-insurance is a socially desirable alternative to costly state regulations.
4. State governments also will be responsible for operating local Health Care Safety Nets.
5. Once the federal financial obligation is discharged, state and local governments will assume funding responsibility for any remaining problems.

B. CREATING OPTIONS FOR LOCAL HEALTH CARE SAFETY NETS

1. Although state governments are obligated to spend federal safety net money on the uninsured, they can discharge this obligation in many ways.
2. One way is to set up clinics that dispense free services to the low-income uninsured.
3. Another is to enroll the uninsured in an expanded Medicaid program (although, see the discussion below).
4. A third option is to supplement the federal grant and assist people in obtaining private health insurance.

C. ALLOWING DISCRETION WHILE REWARDING GOOD CHOICES

1. Many states subsidize the purchase of private insurance by piggybacking on federal practice; they exclude employer payments from employee taxable income and/or create special tax relief for low-income families.
2. These states could continue their current practices or adopt a tax credit at the state level; most will quickly discover that the latter is a better use of state resources.

3. States also will be allowed to supplement the federal tax credit with a state tax credit they design, and many probably will do so.

4. In general, states will find it in their interest to encourage private insurance, because private insurance will almost always involve an input of private resources through the family premium contribution, whereas the state burden will be greater if people depend on state and local funds to meet all their health care needs.

"Ultimately, low-income families should be given a private insurance alternative to Medicaid."

5. Many states have contributed to the growing number of uninsured through unwise regulations.

6. These states could continue such practices, but they will pay a heavy (budgetary) price for doing so.

7. Since the federal commitment under this plan is fixed, the federal government cannot be held hostage to the vagaries of state law.

XI. AN ALTERNATIVE TO MEDICAID

A. CREATING OPTIONS FOR LOW-INCOME FAMILIES

1. Low-income families on Medicaid have traditionally faced limited options in the medical marketplace.

2. Where Medicaid benefits have been improved, improvements have come at the cost of HMO-type restrictions.

3. The refundable health insurance tax credit offers low-income families an alternative — a source of funds with which to buy private insurance.

B. INTEGRATING MEDICAID WITH THE TAX CREDIT SYSTEM

1. Ultimately, Medicaid should be integrated with the tax credit system.

2. States should be allowed to voucherize their Medicaid programs, using Medicaid money to supplement funds available through the refundable health insurance tax credit to allow enrollees the full range of private insurance options.

C. ENCOURAGING PRIVATE INSURANCE ALTERNATIVES TO MEDICAID

1. Even without Medicaid reform, care must be taken to insure that the tax credit system does not inadvertently encourage the expansion of Medicaid.

2. Thus the new plan allows states to receive Medicaid matching funds for a family or a contribution to a Health Care Safety Net — but not both.

3. In most cases the federal contribution to the Safety Net will be larger than the potential federal match as a result of Medicaid enrollment.

XII. FUNDING REFORM

"This program can be funded with money currently used for tax subsidies and health spending programs."

A. USING SAVINGS FROM ENDING THE CURRENT TAX SYSTEM

1. Currently, the United States spends more than $100 billion on tax subsidies for employer-provided health insurance, with much of the money subsidizing wasteful overinsurance and rewarding higher-income families who would have purchased insurance without the subsidy.

2. Moving to a tax credit system will allow employers and employees to avoid many wasteful practices without losing tax benefits.

3. As employers and employees shift to more economical health plans, employer tax-deductible expenses for health insurance will fall and taxable wages will rise.

4. The extra taxes the federal government collects from the larger taxable wage base will be a source of funding to insure the currently uninsured.

B. USING SAVINGS FROM REDUCTIONS IN CURRENT SPENDING PROGRAMS

1. Federal and state spending on health programs for the uninsured currently exceeds $1,000 for every uninsured person in America.

2. If all of the uninsured suddenly became insured, this would free up more than $40 billion a year in current spending.

3. Savings made possible by scaling back spending programs (as the need diminishes) will be a source of funds to finance the tax credit and the Safety Net program.

C. ACHIEVING BUDGET NEUTRALITY

1. America does not need to spend more money on health care — $1 trillion a year is ample money to meet the nation's health care needs.

2. The goal of health reform should be to redirect government subsidies and government spending so that those dollars are used more wisely and more fairly.

John C. Goodman
Merrill Matthews
National Center for Policy Analysis

"We don't need more spending on health care; we need to use government money more wisely and more fairly."

About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute founded in 1983 and funded exclusively by private contributions. The mission of the NCPA is to seek innovative private-sector solutions to public policy problems.

The center is probably best known for developing the concept of Medical Savings Accounts (MSAs). The *Wall Street Journal* called NCPA President John C. Goodman "the father of Medical Savings Accounts." Sen. Phil Gramm said MSAs are "the only original idea in health policy in more than a decade." Congress approved a pilot MSA program for small businesses and the self-employed in 1996 and voted in 1997 to allow Medicare beneficiaries to have MSAs.

Congress also relied on input from the NCPA in cutting the capital gains tax rate and in creating the Roth IRA. Both proposals were part of the pro-growth tax cuts agenda contained in the Contract with America and first proposed by the NCPA and the U.S. Chamber of Commerce in 1991. Two other recent tax changes — an increase in the estate tax exemption and abolition of the 15 percent tax penalty on excess withdrawals from pension accounts — also reflect NCPA proposals.

Another NCPA innovation is the concept of taxpayer choice — letting taxpayers rather than government decide where welfare dollars go. Sen. Dan Coats and Rep. John Kasich have introduced a welfare reform bill incorporating the idea. It is also included in separate legislation sponsored by Rep. Jim Talent and Rep. J. C. Watts.

Entitlement reform is another important area. NCPA research shows that elderly entitlements will require taxes that take between one-half and two-thirds of workers' incomes by the time today's college students retire. A middle-income worker entering the labor market today can expect to pay almost $750,000 in taxes by the time he or she is 65 years of age, but will receive only $140,000 in benefits — assuming benefits are paid. At virtually every income level, Social Security makes people worse off — paying a lower rate of return than they could have earned in private capital markets. To solve this problem, the NCPA has developed a 12-step plan for Social Security privatization.

The NCPA also has developed ways of giving parents the opportunity to choose the best school for their children, whether public or private. For example, one NCPA study recommends a dollar-for-dollar tax credit up to $1,000 per child for money spent on tuition expenses at any qualified nongovernment school — a form of taxpayer choice for education.

The NCPA's Environmental Center works closely with other think tanks to provide common sense alternatives to extreme positions that frequently dominate environmental policy debates. In 1991 the

NCPA organized a 76-member task force, representing 64 think tanks and research institutes, to produce *Progressive Environmentalism*, a pro-free enterprise, pro-science, pro-human report on environmental issues. The task force concluded that empowering individuals rather than government bureaucracies offers the greatest promise for a cleaner environment. More recently, the NCPA produced *New Environmentalism*, written by Reason Foundation scholar Lynn Scarlett. The study proposes a framework for making the nation's environmental efforts more effective while reducing regulatory burdens.

In 1990 the NCPA's Center for Health Policy Studies created a health care task force with representatives from 40 think tanks and research institutes. The pro-free enterprise policy proposals developed by the task force became the basis for a 1992 book, *Patient Power*, by John Goodman and Gerald Musgrave. More than 300,000 copies of the book were printed and distributed by the Cato Institute, and many credit it as becoming the focal point of opposition to Hillary Clinton's health care reform plan.

A number of bills before Congress promise to protect patients from abuses by HMOs and other managed care plans. Although these bills are portrayed as consumer protection measures, NCPA studies show they would make insurance more costly and increase the number of uninsured Americans. An NCPA proposal to solve the problem of the growing number of Americans without health insurance would provide refundable tax credits for those who purchase their own health insurance.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA experts appear regularly in national publications such as the *Wall Street Journal, Washington Times* and *Investor's Business Daily*. NCPA Policy Chairman Pete du Pont's radio commentaries are carried on 359 radio stations across America. The NCPA regularly sponsors and participates in *Firing Line Debate*, which is aired on 302 public broadcasting stations. The NCPA each year sponsors 22 one-hour televised debates on the PBS program *DebatesDebates*, seen in more than 170 markets.

According to Burrelle's, the NCPA reached the average household 10 times in 1998. More than 36,000 column inches devoted to NCPA ideas appeared in newspapers and magazines in 1997. The advertising value of this print and broadcast coverage was more than $56 million, even though the NCPA budget for 1998 was only $4 million.

The NCPA has one of the most extensive Internet sites for pro-free enterprise approaches to public policy issues, receiving about one million hits (page views) per month. All NCPA publications are available online, and the website provides numerous links to other sites containing related information. The NCPA also produces an online journal, *Daily Policy Digest*, which summarizes public policy research findings each business day and is available by e-mail to anyone who requests it.

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