State Health Care Reform Under the Clinton Administration

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NCPA Policy Report No. 173
November 1992
ISBN 0-943802-76-8

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Executive Summary

As state governments take on the difficult task of health care reform, legislators must accept the fact that federal policy — particularly tax policy — has shaped and molded our health care system. Since the states cannot change federal policies, they cannot address the root causes of most of our problems. Specifically, state governments cannot change the following facts:

- Federal tax law encourages a system of first-dollar health insurance coverage, under which patients make wasteful purchases because the money they spend is not their own.
- Every time the federal government spends an extra dollar on health care only 35 cents buys real services, while 65 cents adds to health care inflation for all patients.
- Federal tax law subsidizes an employer-based health insurance system, under which people eventually lose coverage when they switch jobs.
- Although federal tax law generously subsidizes employer-provided health insurance, very little tax relief is given to people who must purchase their own health insurance.
- Most of the benefits from federal health care spending and federal tax subsidies for health insurance go to families who are not poor and do not need help from government.

What can state legislators do to help the private sector control costs and expand access to affordable health insurance? They can begin by repealing state laws that make the current problems worse.

- Laws that require one-price-for-all health insurance are forcing up premiums for healthy people and causing more of them to be voluntarily uninsured.
- State mandated health insurance benefits are increasing costs and have priced as many as one out of every four uninsured people out of the market.
- Overregulation is preventing people who live in rural areas from using limited resources in sensible ways to meet health care needs.
- Last year, 195 pieces of state legislation were introduced to stop, or cripple, managed care and other cost control techniques.

State governments will only make their problems worse if they try to force employers to provide health insurance, control spending through "global budgets" or adopt a state-based version of national health insurance.

They can begin to solve problems through market-based solutions by encouraging competitive markets for health insurance and for physician and hospital services, by creating Medical Enterprise Zones and by encouraging policies that empower people rather than health care bureaucracies.

Outline

Introduction

For the past four years, the Bush administration has encouraged state governments to experiment with health care reform — to find out what will and will not work. Although the details of Bill Clinton's health care plan are not available, it seems likely that the states will continue to exercise considerable discretion in health policy over the next four years.

So far, the states have responded by considering a wide variety of reform proposals. Yet it is the federal government that bears most of the responsibility for our national health policy crisis. For example, the federal government is primarily responsible for rising health care costs, the rising number of people who lack health insurance and the failure to establish a national health care safety net for low-income people. Because state governments cannot change faulty federal policies, their options are limited. Quite simply, they have enormous power to do harm and far less ability to do good.

What follows is a review of what state governments can and can't change in the market for health care, with an analysis of the best and worst reforms that the states can enact.

What State Governments Can't Change: Federal Policies that Increase Costs

"Unwise federal policies are the chief cause of rising health care costs."

Unwise federal policies are the chief cause of rising health care costs for three reasons: federal tax law encourages wasteful spending in the private sector; the design of federal health programs causes wasteful spending in the public sector; and direct federal spending keeps upward pressure on health care costs. State governments may attack the symptoms by imposing price controls [see the discussion below], but they cannot affect the underlying problem.

Rising Costs Due to Federal Tax Policy. The primary reason why health care spending is out of control is that most of the time when we enter the medical marketplace as patients we are spending someone else's money rather than our own. Economic studies — as well as common sense — confirm that we are less likely to be prudent, careful shoppers if someone else is paying the bill. Although polls show that most people fear they will not be able to pay their medical bills from their own resources, the reality is that few of us will have to. On the average:[1]

- Every time we spend a dollar in a hospital, we pay only 5 cents out-of-pocket and 95 cents is paid by a third party (employer, insurance company or the government).

- Every time we spend a dollar on physicians' fees, we pay less than 19 cents out-of-pocket.

- For the health care system as a whole, we pay only 23 cents out-of-pocket every time we consume a dollar's worth of services.

Moreover, the explosion in health care spending over the past three decades parallels the rapid expansion of third-party payment of medical bills. The patient's share of the bill has declined from 56 percent in 1960 to 23 percent today. There is substantial evidence that a great deal of waste in our health care system is caused by people who have too much insurance. For example, Rand Corporation studies imply that if every family in America had a $2,500 deductible,[2] personal health care spending would drop as much as one-fourth[3] with no adverse effects on health.[4] Market prices for health insurance also provide powerful evidence of the wastefulness of low deductibles:[5]

"Evidence indicates that too much health insurance results in wasteful spending."

- If a family in a city with average health care costs increases its deductible from $250 to $1,000, its premium savings will be $1,315 — almost twice the amount of the increase in the deductible.[6]

- If the family increases its deductible from $250 to $2,500, it will save $1,749 on premiums — roughly the amount of coverage the family would forgo, considering the effects of the deductibles and copayment.[7]

Most individuals and families would be much better off if they had the opportunity to choose high deductibles and place the premium savings in an account to be used for small medical bills.[8] Yet, while the federal government generously subsidizes third-party insurance, it discourages self-insurance by heavily taxing funds that individuals put aside for medical expenses:

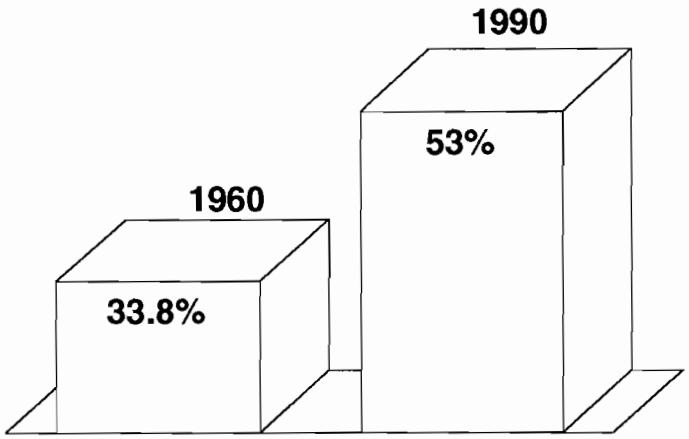
- Under current law, every dollar of health insurance premiums paid by an employer escapes, say, a 28 percent income tax, a 15.3 percent Social Security (FICA) tax and a 4, 5 or 6 percent state and local income tax, depending on where the employee lives.

- On the other hand, these taxes are imposed on every dollar of income that employees try to save.

"Government now spends more than half of all health care dollars."

FIGURE I

Government Spending as a Share of All Health Care Spending[1]



[1]Includes tax subsidies for health insurance.

Source: NCPA/Fiscal Associates health care model.

- Thus government is effectively paying up to half of the premiums for third-party health insurance and taxing up to half of the income people try to save.

The federal government could eliminate this distortion by giving just as much tax incentive to individual self-insurance as it now gives to third-party insurance. [See sidebar on Medical Savings Accounts.] Without this change, there is little reason to think health care costs can be controlled without government-imposed health care rationing. Although some state governments (including Oklahoma) are considering Medical Savings Accounts, the effect of federal tax law is so large that state efforts alone are likely to accomplish little.[9]

Rising Costs Due to Federal Spending. Prior to 1960, health care spending as a percent of gross national product (GNP) increased very slowly in the United States. After the enactment of Medicare and Medicaid in 1965, however, health care spending soared:

- Between 1940 and 1960, health care spending rose modestly, from 4 percent of GNP to 5.2 percent.
- Since 1960, the percent of gross domestic product (GDP) spent on health care has almost tripled, reaching an estimated 13.4 percent in 1992.[10]

When federal tax subsidies for health insurance[11] are combined with direct spending, government at all levels (federal, state and local) now spends more than half of all health care dollars. Moreover, spending on Medicare and Medicaid has skyrocketed from 5.9 percent of total health care spending in 1967, the first full year of the two programs, to 28 percent in 1990.[12] Overall:[13]

- Direct government spending has increased from 24 percent of all health care spending in 1960 to 42 percent in 1990.
- When tax subsidies for health insurance are included, the government's share of health care spending has increased from 33.8 percent in 1960 to 53 percent today. [See Figure I.]

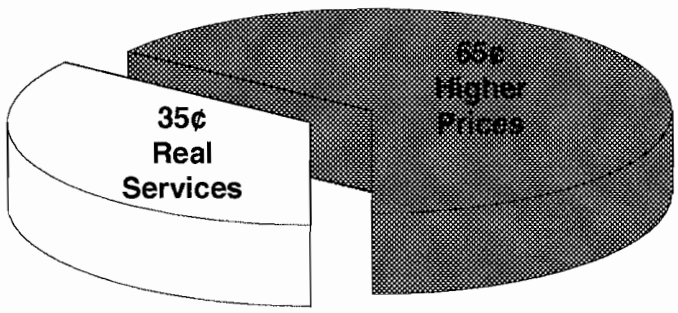
Many view Medicare and Medicaid as necessary programs, providing services to people who would not otherwise be able to afford them. But increased government spending has mainly increased prices rather than services:

- According to the Health Care Financing Administration (HCFA), which administers Medicare, every extra dollar spent on health care buys 65 cents in increased prices and only 35 cents in real services.[14] [See Figure II.]

"Increased government spending has mainly increased prices rather than services."

FIGURE II

What an Extra Dollar of Health Care Spending Buys



Source: Health Care Financing Administration.

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

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

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

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

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

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

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

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

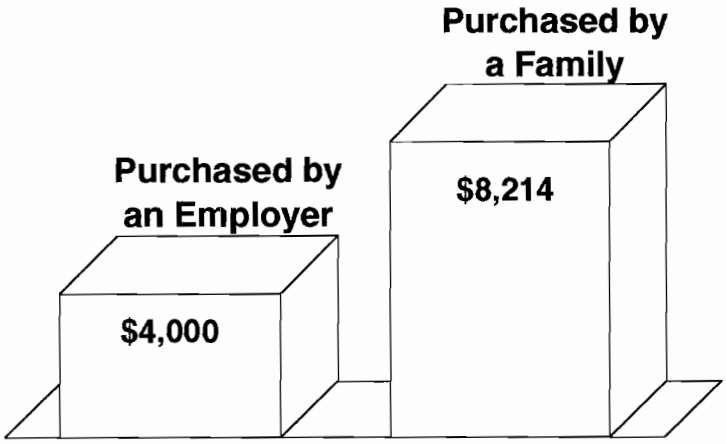
If most medical expenses were paid by people using their own Medical Savings Account funds, patients would have a financial self-interest in eliminating waste and reducing costs in the medical marketplace, and they would acquire greater control over how their health care dollars were spent. Third-party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

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

"The effective cost of health insurance is twice as high for people who buy their own policy."

FIGURE III

Effective Cost of a $4,000 Health Insurance Policy[1]



[1] Figures show the amount of additional pretax income that must be earned in order to purchase the policy. The family is assumed to have adjusted gross income of $35,000 and to face a 28 percent federal income tax rate, a 15.3 percent Social Security (FICA) tax rate and an 8 percent combined state and local income tax rate.

Source: Aldona Robbins and Gary Robbins, Fiscal Associates.

- According to the NCPA/Fiscal Associates health care model, every extra dollar spent on health care buys 57 cents in increased prices and only 43 cents in real services.[15]

Rising Costs Due to the Design of Federal Health Programs. In the Medicaid and Medicare programs, the federal government has codified wasteful first-dollar coverage. For example, Medicare pays many expenses that most patients could pay with their own resources — a practice that encourages overconsumption by Medicare patients who see few reasons to compare the value of diagnostic tests or physician visits with other uses of the same money.[16] Federal regulations governing the Medicaid program also limit the ability to charge patients for low-cost items.[17]

The federal government also has adopted other policies that impede cost control. City and county health officials can point to many federal rules and regulations that prevent them from spending health care dollars wisely. For example, almost one-fourth of all Medicaid spending is for nursing home care. But federal regulations impose tight restrictions on the type of facility that can be used as a nursing home and prohibit less costly, equally effective alternatives.[18]

What State Governments Can't Change: Federal Tax Subsidies for Employer-Based Insurance

"Employer-provided health insurance is an artificial result of federal tax law."

The kind of health insurance most of us have is determined by what the federal tax law subsidizes. This has led to an employer-based system under which people lose their health insurance when they switch jobs.[19] Moreover, not everyone is treated equally. General Motors employees have one of the most lavish health insurance plans in the world — with Uncle Sam footing up to half of the cost. At the same time, the self-employed, the unemployed and employees of small companies that do not provide health insurance are discriminated against.[20] They must pay taxes first and buy health insurance with what's left over. As Figure III shows, this makes their effective price of health insurance twice as high as the price for people who have employer-provided insurance. Small wonder that almost 90 percent of the population under 65 years of age with health insurance is insured through an employer.[21]

Under current employee benefits law, employers have few opportunities to institute sound cost-containment practices without substantial income tax penalties, and employees have few opportunities to purchase less costly health insurance or policies tailored to individual and family needs.

How Federal Policy Affects Small Business.[22] Suppose a small firm is considering purchasing an individual health insurance policy for each employee in order to take advantage of the favorable treatment of health insurance under the tax law. As Table 1 shows, this firm will immediately confront four problems. First, the cost of the policy will vary with the age of the employee. (A 60-year-old male, for example, is about three times more expensive to insure than a 25-year-old male.) The obvious solution is to pay the premiums for the policies and reduce each worker's salary by the premium amount. Second, not all employees may want health insurance (e.g., some may be covered by another policy). The obvious solution is to give health insurance only to those employees who want it, reducing the salary of each by the amount of the premium. Third, some employees may have preexisting illnesses, and the insurer may want to insert exclusions and riders into their policies. The obvious solution is to get each employee the best possible deal. And fourth, employees may have different preferences about the content of their policies. Some may want to trade off a higher deductible for a lower premium. Others may want coverage for different types of illnesses and medical services (e.g., infertility coverage). The obvious answer is to let each employee choose a policy best suited to the employee's needs and preferences.

Despite the fact that these solutions seem obvious and that every employee may gain from them, they are generally unavailable. In general, the federal tax law forbids employees from choosing between wages and health insurance and insists that all employees be offered the *same* coverage on the *same* terms. The result is that the employer must turn to a more expensive group policy with a package of benefits that no single employee may want.

How Federal Policy Contributes to Rising Costs. One consequence of the barriers described above is that employers are forced to adopt a health care plan in which *benefits are individualized,* but *costs are collectivized.* Although large employers have a few more options, they too are forced into a system which has two devastating defects.

First, under the current system there is no direct relationship between health insurance premium costs and individual employee wages. In many cases employees do not know what the premiums are. In those cases where they do (e.g., where they are asked to pay part of the premium), each is charged the same premium — regardless of age, sex, place of work, type of work or any other factor that affects real premium costs. The upshot is that the individual employee sees no relationship between the cost of employer-

"Each employee should be permitted to choose a policy best suited to his or her own needs."

TABLE I

Solving Health Insurance Problems for Employers and Employees

Problem	Solution
Employees have different preferences about health insurance coverage (e.g., deductibles, types of service covered, etc.).	**Allow each employee to choose a policy best suited to individual and family needs.**
Costs differ by age, sex, type of job and other employee characteristics.	**Reduce each employee's gross salary by the amount of that employee's premium.**
Not all employees want or need employer-provided coverage.	**Give health insurance only to employees who want it.**
Some employees have preexisting illnesses.	**Negotiate the best coverage possible for each individual employee.**

provided health insurance and personal take-home pay. Small wonder that employees of large companies demand lavish health care benefits.

Second, under conventional employer health plans there is no relationship between wasteful, imprudent health care purchases and salary. Under most policies, it is as though the employee has a company credit card to take to the hospital equivalent of a shopping mall. The employee will find many interesting things to buy, all chargeable to the employer. Under this system, employees have no personal incentives to be careful, prudent buyers of health care.

"Employees see no relationship between the cost of employer-provided health insurance and personal take-home pay."

How Federal Policy Causes More People to be Uninsured. In the face of constraints imposed by federal policy, employers are trying to hold down health care costs by taking actions that have very negative social consequences. Unable to adopt a sensible approach to employee health insurance, many large firms are asking employees to pay (with aftertax dollars) a larger share of the premium. Often employers pay most of the premium for the employee, but ask employees to pay a much larger share for their dependents.[23] These practices result in some employees' opting not to buy into an employer's group health insurance plan. More frequently, employees choose coverage for themselves but drop coverage for their dependents. Three million people who lack health insurance are dependents of employees who are themselves insured.[24]

Because employee benefits law prevents smaller firms from adopting a sensible approach to employee health insurance, many are responding to rising health insurance premiums by canceling their group policies. Often, employers give bonuses or raises to pass along their corporate savings and encourage employees to buy individual health insurance policies (with aftertax dollars). Many, of course, do not.

Needed Changes in Federal Policies. Most proposed state health care reforms operate either through employers or through government. As a result, they fail to consider all of the other options. This is not so strange when we consider that employee benefits and tax payments are both tax deductible, whereas every other method of paying for health care is not. Thus the federal tax system has greatly constrained the types of reforms state governments can realistically consider. Two important federal policy changes would help solve a great many problems for individuals, employers and state legislators.

First, health insurance benefits should be made personal and portable, with each employee free to choose an individual policy and keep it in spite of

Federal Policy Changes Needed for Employer-Based Health Insurance

One of the great ironies of employee benefits law is that, although it was designed to encourage the purchase of health insurance, its more perverse provisions are increasing the number of people without health insurance. [See Table I.] Because employers cannot individualize health insurance benefits, many are turning to other practices that are increasing the number of uninsured people.

To remedy these problems, the following changes are needed. (1) Health insurance benefits should be made personal and portable. (2) Health insurance premiums should be included in the gross wages of employees, with tax credits for those premiums allowed on individual tax returns. (3) The size of the tax credit should vary inversely with employee income — so that the most help is given to those with the lowest incomes. (4) The tax credit should be limited to encourage the purchase of a no-frills, catastrophic policy — and those who purchase more generous coverage should do so with aftertax dollars. (5) Individual employees should have the opportunity to choose between lower wages and more health insurance coverage (and vice versa). (6) Individual employees should be free to choose among all health insurance policies sold in the market place.

These recommendations would have several advantages:

- Rising health care costs would no longer be a problem for employers — health insurance premiums would be a direct substitute for wages.
- Employees would have opportunities to choose lower-cost policies and higher take-home pay.
- Employees would have the opportunity to select policies tailored to their individual and family needs.
- Employees would be able to retain the tax advantages of the current system but avoid the waste inherent in collectivized benefits.
- Employees would be able to continue coverage at actuarially fair prices if they quit work or switched jobs.
- Those employees with lowest incomes would get the most help from government through the tax law.

When there is a direct link between salary and health insurance premiums, employees will be more prudent about the policies they choose. Those who want policies with no deductibles and all the bells and whistles will pay the full premium cost in the form of a salary reduction. Faced with a real choice, employees are more likely to choose high-deductible, no-frills catastrophic coverage.

Sources: Task Force Report, "An Agenda for Solving America's Health Care Crisis," National Center for Policy Analysis, NCPA Policy Report No. 151, May 1990; and Stuart Butler and Ed Haislmaier, *A National Health System for America* (Washington, DC: Heritage Foundation, 1989), ch. 3.

job changes. Health insurance benefits should be included in the gross wages of employees, who could claim deductions or tax credits for premiums on their personal tax returns — directly gaining from prudent choices and bearing the direct costs of wasteful ones. [See the sidebar on federal policies needed to solve the problems of employer-based insurance.]

Second, the federal tax law should give just as much tax encouragement to those who purchase their own health insurance as to employer-provided insurance and base the size of the subsidy on family need. [See the sidebar on "A Play-or-Pay Plan that Works."]

What State Governments Can't Change: Federal Programs that Undermine the Social Safety Net

All too often, help from the federal government goes to those who need it least. Both tax and spending policies are designed to undermine a reasonable social safety net.

"This year the federal government will 'spend' about $60 billion in tax subsidies for health insurance."

Regressive Tax Subsidies for People with Health Insurance. This year the federal government will "spend" about $60 billion in tax subsidies for health insurance. These subsidies will be distributed in a highly regressive way for two reasons. First, the ability to exclude employer-provided health insurance from taxable wages is more valuable to employees in higher tax brackets. Second, by restricting this tax subsidy to employer-provided insurance, the law favors people who work for larger firms. The result is a system that favors high-income over low-income families. As Figure IV shows:

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

Tax Penalties for the Uninsured. A common fallacy is that people who lack health insurance are getting a free ride at the expense of the rest of us. When the uninsured get sick, it is argued, they usually get medical care.

Federal Policy Needed to Insure the Uninsured: A Play-or-Pay Plan that Works

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

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

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

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

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

Strengthening the Social Safety Net. Funds for indigent health care could go to local health care agencies (LHCAs), which would be responsible for providing uncompensated health care. Those lacking private health insurance and not covered by a federal health insurance program would be self-insured for the amount of their personal assets. Once an individual's assets were depleted, the remaining costs would be paid by an LHCA — just as Medicaid currently assumes financial responsibility for private-pay patients who enter nursing homes.

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

And when they can't pay for it, the rest of us pay through cost shifting or higher taxes.

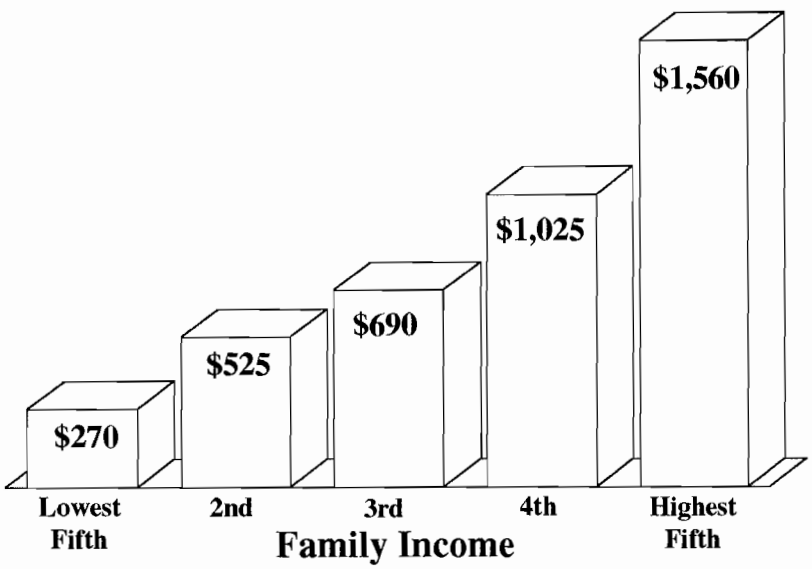
What this argument overlooks is that the uninsured pay higher taxes precisely *because* they do not get tax subsidies. The problem is that the extra taxes go to Washington while the free care is delivered locally. A reasonable reform would be to require the federal government to return the extra taxes to the providers that deliver uncompensated care. [See sidebar on "A Play-or-Pay Plan that Works."]

Regressive Spending Programs. This year the federal government will spend about $215 billion on health care. How much goes to low-income families who need help? Surprisingly little. Only one out of every four dollars spent by the federal government goes to a poor family that qualifies for benefits under a means-tested program. The bulk goes to middle- and upper-middle-income families, even though the taxes used to pay for these benefits often come from low-income workers. For example, take the $130 billion the federal government spends on Medicare. Under the program:

"High-income families get about six times as much help from government as low-income families."

FIGURE IV

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



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

Source: C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference, American Health Policy, Washington, DC, October 3-4, 1991.

- The lowest income workers pay 2.9 percent of their income to support Medicare.

- Yet the primary beneficiaries of Medicare — the elderly — have higher after-tax incomes and considerably more assets than the nonelderly.[25]

For the most part, federal health dollars benefit the nonpoor. In the process, they force up prices for the poor.

What State Governments Can't Change: Federal Responsibility for the Plight of the Elderly

About one-third of all employees work for an employer who provides postretirement health care benefits, covering items not paid for by Medicare.[26] Yet partly because of federal tax law, many of these workers will never collect a dime of those benefits. At the same time, the federal government's Medicare program covers many small items the elderly could easily pay for themselves, while leaving them exposed to catastrophic medical bills. Such policies place the burden of catastrophic coverage on individual families and state and local governments.

"Federal tax law allows unlimited spending for current health care needs, but discourages savings for postretirement health care."

Employer-Provided Health Insurance. Although federal tax law allows unlimited spending for current health care needs — and excludes all of it from employee income — it severely limits the ability of the private sector to save for postretirement health care.[27] As a result, most employers have not put aside funds to pay for future promises:[28]

- According to one estimate, unfunded liabilities of employers for postretirement health care now total $332 billion.

- This is equal to about 30 percent of the net worth of large companies.

Not only does federal tax law discourage employers from saving for postretirement medical expenses, but it also discourages individuals. Although the tax system generously subsidizes current health care spending, the government taxes personal savings and provides no deduction for long-term care insurance.

Medicare. As noted, the federal government pays many small medical bills for Medicare patients. For example:[29]

- Following a deductible of $100, Medicare pays 80 percent of all remaining physicians' fees.
- Medicare pays all expenses for the first 20 days in a nursing home.
- Following a deductible of $652, a Medicare patient faces no additional costs for a hospital stay of up to 60 days.

"Medicare offers too much first-dollar coverage and too little catastrophic coverage."

Unfortunately, Medicare leaves the elderly exposed for the most expensive bills — paying nothing after the 100th day in a nursing home and the 150th day in a hospital. Moreover, because Medicare offers too much first-dollar coverage and too little catastrophic coverage, state and local governments often must pick up the tab when catastrophic illnesses occur.

Medigap Insurance. The bias toward front-end coverage extends to federal laws governing private insurance designed to pay expenses not paid by Medicare. These policies are required to pay small-dollar claims but are free to skimp on catastrophic coverage in the same way that Medicare does.[30]

What State Governments Shouldn't Change: Insurance that Is Exempt from State Regulation

There is something intrinsically wrong with a policy proposal if its proponents argue that in order to reform health insurance and health care delivery for *some* people, all *other* people must be included. Yet that's what many state reformers are arguing.

Currently, federal employees, employees of self-insured companies and Medicare enrollees are exempt from state health insurance regulations — mandated benefits, premium taxes, forced risk pool contributions and other cost-increasing taxes and regulations. Some reformers want to end that exemption.

Take self-insured companies, for example — companies that pay employees' health care claims themselves instead of relying on outside insurance companies.[31] More than half of the nation's labor force works for a self-insured company, and state regulations are a major reason why. Health economists Jon Gabel and Gail Jensen looked at a sample of 280 firms that were not self-insured in 1981.[32] By 1984, 24 percent had chosen self-insurance. Using a model that correctly predicted a firm's decision to self-insure 86 percent of the time, they found that:

- Increasing the state premium tax from 1 percent to 3 percent increased the probability of self-insuring from 20 percent to 24 percent.

- Imposing a risk pool and mandating continued coverage increased the probability by 55.8 percent and 165.6 percent, respectively.

- Mandates for psychological treatment raised the probability of self-insuring (by 93.2 percent), as did mandates for alcohol treatment (5.9 percent) and drug dependency treatment (58.8 percent), although the latter two mandates were not statistically significant.

- The impact of all state regulations taken together caused half of the firms that self-insure to make that decision.

"Large companies are self-insured to avoid state regulations."

Despite the fact that employers turn to self-insurance to avoid cost-increasing state regulations, a delegation of 14 governors recently went to the White House seeking the Bush administration's support for a proposal to end the exemption for self-insured companies.[33] Among other goals, the governors wanted to overturn the effects of a federal court ruling that the state of New Jersey cannot impose a 19 percent tax on the hospital bills of employees of self-insured plans.[34] Fortunately, the Bush administration has resisted.

What States Can Do: The Best and Worst Ideas

Most of the state health care reform proposals being seriously considered are likely to do more harm than good. Before considering specific proposals, let's take a closer look at the visions behind them.

Two Competing Visions. One reason why health care debates rarely resolve anything is that the debaters often rely on diametrically opposed assumptions — assumptions that are rarely disclosed. Those who hold a "bureaucratic" vision of health care invariably talk of "needs" and "resources." They rarely mention the word "individual." Those who hold an "individualistic" vision know that all behavior is individual and that behind most serious social problems is a system of distorted individual incentives. The individualistic vision leads one to identify and eliminate these distortions. The bureaucratic vision leads one to expand and multiply them.

Individuals vs. Bureaucracies. When forced to confront the reality of individual choice and behavior, those who hold a bureaucratic vision of health care invariably point to unconscious patients in hospital emergency

rooms — arguing that choice is impossible. They conveniently ignore the fact that probably 80 percent of all procedures are elective and that, in the vast majority of cases, patients have ample opportunity to reflect and choose. It would be a mistake, however, to conclude that the bureaucratic vision cannot see past the hospital emergency room. The issue is much more profound. Many who hold the bureaucratic vision are fundamentally anti-individual and anti-choice. They oppose individual empowerment on principle.

Three Assumptions Behind the Worst Health Care Reform Proposals. Behind the bureaucratic vision of health care are three bad assumptions. To one degree or another, they are responsible for most unworkable reform proposals. They are:

- No one — especially not patients, but preferably not even physicians or hospital personnel — should be forced to choose between health care and other uses of money.
- Insurance premiums (or payments for government-provided insurance) should never reflect individual health risks.
- Decisions by bureaucracies are always better than decisions by individuals.

When a health care system is based on these assumptions, social problems are inevitable. To the degree that patients perceive health care as free, they will overconsume health care resources. If insurance prices do not reflect real risks, some people will be overcharged and others undercharged. Those who are undercharged will overinsure (or demand more insurance from their employer or through the political system). Those who are overcharged will tend to be underinsured. When power is concentrated in the hands of bureaucracies, individual incentives are distorted in hundreds of ways, and people find it in their self-interest to take actions that defeat legitimate social goals.

"Many who hold the bureaucratic vision are fundamentally anti-individual and anti-choice."

Three Assumptions Behind the Best Health Care Reform Proposals. The individualistic vision of health care recognizes that we will get better outcomes in the long run if people bear the costs of their bad decisions and reap the benefits of their good ones. On the whole, good incentives for individuals lead to good social outcomes. Accordingly:

- Since society as a whole must choose between health care and other uses of money, as often as possible those choices should be made by individual patients.

- Although society as a whole may choose to subsidize the less fortunate, most people should pay the real cost of what they get — in medical care and in health insurance.

- Ideal institutions are based on social goals that are consistent with the self-interested behavior of individuals.

Reform proposals based on these assumptions are likely to improve our health care system. Reform proposals that reject these assumptions are likely to make our health care crisis worse.

The United States vs. Other Developed Countries. The three assumptions underlying the bureaucratic view of health care have been fully accepted and institutionalized in every other developed country. They have also been influential in our own. In fact, they formed the basis for the original Blue Cross/Blue Shield vision and shaped the development of our largely private health insurance system. Blue Cross believed that anyone who had a health insurance deductible or copayment requirement was underinsured, that the ideal policy was first-dollar coverage for all medical expenses, and that everyone should be charged the same price for health insurance — regardless of any indicator of health risk.[35]

"Whereas other countries chose public sector socialism, the United States chose private sector socialism."

Whereas other countries chose public sector socialism, the United States chose private sector socialism. The mechanisms were different, but the ideals were the same. Indeed, one reason why the United States is perceived to have greater health policy problems than most other countries is that we have more successfully implemented a system based on the three bad assumptions. Virtually every major corporation in America has institutionalized the system of community rating originally favored by Blue Cross.[36] And ours is the only country in which people can freely enter the medical marketplace, consume every service from an MRI scan to a cholesterol test and have most of the bill paid by someone else.

Problem: Health Insurance Reform

Serious problems exist in the market for private health insurance. Among them: (1) many people discover that after they get sick their insurance can be canceled or they can face unreasonable premium increases; (2) employees find that when they leave employment they lose insurance coverage, even if they have a medical problem; and (3) people with medical problems who lose coverage may find that no other insurer will insure them.[37]

In theory, the problems in the market for private health insurance are not difficult to solve. [See the sidebar on solving the crisis in private health

insurance.] In practice, they have so far proved impossible. A number of proposals which purport to solve these problems would in fact make them worse. Some would also exacerbate other problems — causing more people to be uninsured and contributing to rising health care costs.

Good Idea: Guaranteed Renewable Insurance. Most of the problems in the market for private health insurance do not exist in the market for life insurance, which can easily be taken as a model. Once a person becomes insured, health insurers should be required to continue to offer coverage in the future at reasonable prices.[38]

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

With this reform, the market for small group health insurance would begin to resemble the market for individual life insurance policies. In the latter, insurers cannot selectively raise prices for different policyholders based on last year's experience. The same premium increase must apply to the entire class of people who purchase a particular type of policy. Thus insurers cannot change the rules of the game for a single policyholder *after* an illness has occurred.

Good Idea: Collectively Renewable Insurance. There is some evidence that state regulation is largely responsible for the absence of guaranteed renewable health insurance. Insurers have been unwilling to make long-term commitments to policy holders in the face of arbitrary and unpredictable rate regulations.

Even without guaranteed renewability, however, many of the same benefits could be obtained if insurance were required to be collectively renewable. This requirement, which usually applies to individual policies, often is not a feature of policies sold to small groups. Thus insurers can refuse to renew the policy of one employer (because, say, an employee has an expensive illness) while agreeing to renew an identical policy of another employer.

If insurance were required to be collectively renewable, insurers would either have to renew *all* similar policies or *none* of them. They could not single out the healthiest clients and discard the unhealthiest after the policies have been purchased.[39]

Good Idea: Personal and Portable Benefits. As noted above, the federal tax law has encouraged an employer-based system under which people lose their health insurance when they leave a firm. Almost all economists believe that fringe benefits are a substitute for wages. Thus fringe benefits are "paid for" by workers in the form of lower take-home pay. Yet today's employees have no ownership rights. Employers can cut back on coverage,

even after an employee gets sick.[40] And when employees with a preexisting illness leave, they may find it impossible to get insurance elsewhere. A much fairer system would be one under which no tax subsidy is available for employer-provided health insurance unless the policy is personal and portable. State governments cannot change federal tax law. But they can adopt policies that encourage personal and portable health insurance benefits.[41]

Bad Idea: Guaranteed Issue. An ideal insurance market is one in which risk is priced accurately. Each person entering an insurance pool is charged a premium based on the expected cost and risk that person brings to the pool. Put another way, in an ideal insurance market, people pay for what they get.

A number of reform proposals, however, would force insurers to sell policies at fixed prices — no matter how sick or how well the applicants are. Under these proposals, insurers would be forced to overcharge low-risk (healthier) people in order to undercharge high-risk people.[42] Whereas guaranteed renewability would encourage people to purchase health insurance (because they would be confident that once sick, they would be able to continue coverage at reasonable rates), guaranteed issue would have the opposite effect. Why buy health insurance today if you know you can buy it for the same price after you get sick?

"Virtually all studies of guaranteed-issue insurance have concluded that it increases premiums."

Virtually all studies of guaranteed-issue insurance have concluded that it increases premiums.[43] For example, a recent study for the Society of Actuaries compared medically underwritten policies with guaranteed-issue insurance, under which all preexisting illness limitations were waived after 12 months.[44] The study showed that:

- The cost of guaranteed-issue insurance was 23 percent higher the first year and 50 percent higher the second year.[45]
- The seven-year cost of guaranteed-issue insurance was 39 percent higher.[46]
- These numbers imply that if people who are now medically underwritten could buy only guaranteed-issue insurance, from one-fifth to one-half of them would choose to be uninsured.[47]

According to one estimate, no more than seven-tenths of 1 percent of Americans under the age of 65 are uninsurable.[48] Yet in an attempt to make health insurance more affordable for this tiny number, guaranteed-issue reforms would impose price controls and raise premiums for the other 99 percent. The result would almost certainly be a larger number of people who

Solving the Crisis in Private Health Insurance

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

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

Problem: People Who Can Afford to Insure but Choose Not to. Even if tax incentives were offered, some people would choose not to buy health insurance. In that case, they should pay higher taxes. Under the current system, the higher taxes paid by the uninsured go to Washington, while free health care is delivered locally. It would be better to pool the extra taxes and make them available to the hospitals that deliver charity care. That way, uninsured patients would be the payers of first resort, but funding would also be available to provide uncompensated care.

Problem: People Who Are Uninsurable. A small number of people (less than 1 percent of the nonelderly population) cannot buy health insurance because they are sick or at high risk. Government can help by creating risk pools or subsidizing the purchase of conventional health insurance with tax dollars, rather than by artificially raising the premiums charged to healthy people. And the amount of subsidy should depend on family income. Low-income families need government help. Ross Perot does not.

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

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

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

are voluntarily uninsured. [See the sidebar on charging healthy people more for health insurance.]

"Under 'pure' community rating insurers are forced to charge the same price to every policyholder, regardless of age, sex or any other indicator of health risk."

Worst Idea: Community Rating. The concept of guaranteed issue is often combined with community rating. Under "pure" community rating — such as the plan recently adopted in New York [49] — insurers are forced to charge the same price to every policyholder, regardless of age, sex or any other indicator of health risk. Thus, despite the fact that health costs for a 60-year-old male are typically three to four times as high as for a 25-year-old male, both pay the same premium.[50] Under "modified" community rating, price differences are allowed based on age and sex. Other than that, however, sick people are able to obtain health insurance for the same price as healthy people. Thus:

- A person who has AIDS would be able to purchase health insurance for the same price as someone who does not.
- People in hospital cancer wards would be able to buy health insurance for the same price as people who do not have cancer.

Community rating also is being implemented in Vermont and is about to be implemented in Minnesota.[51] Variations on the idea are under consideration in a dozen states. The most important difference among the proposals is the ease with which sick people can enter a pool and healthy people can leave — thus destabilizing the health insurance marketplace. [See the discussion of the Bush plan below.]

Case Study: The Jackson Hole Proposal. An idea implicit in most price-fixing proposals is that health insurers should not engage in the same kinds of activities as insurers in other fields. That idea is explicit in a health care reform proposal developed by Alain Enthoven and other members of the Jackson Hole Group,[52] who argue that insurers should not compete on their ability to price and manage risk but on their ability to manage health care costs.

Under the proposal, insurers would be forced to charge the same premium to all policyholders of the same age (modified community rating)[53] and to accept all applicants (guaranteed issue). The insurers would compete and try to keep their premiums low by developing skills at managed care.[54] To the degree there is a trade-off between cost and quality, insurers would compete based on their ability to manage that trade-off in ways pleasing to potential customers.

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

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

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

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

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

Moreover, the primary reason why most of the uninsured lack health coverage is that they have judged the price too high relative to the benefits. Very few have been denied coverage. The artificial premium increases that would result from many health insurance reform proposals would substantially increase the number of employers who fail to provide coverage for their employees and the number of individuals who are uninsured by choice.

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

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

To see one problem, imagine two competing HMOs. In the first, enrollees can see a primary care physician at the drop of a hat, but there are screening procedures and sometimes lengthy waiting periods for kidney dialysis, heart surgery and other expensive procedures. In the second, dialysis and heart surgery are available when needed, but there are few primary care physicians. Given a choice, most of us would enroll in the first HMO until we really got sick, then switch to the second. But if everyone did that, the second HMO could not survive financially.[55] Just as is the case with national health insurance, absent a market for real insurance there would be a natural tendency to gravitate away from expensive, lifesaving medical technology.[56]

To see another problem, imagine several HMOs offering identical services. Because they must take all applicants at the same premium, each has an incentive to attract healthy people and avoid those likely to generate high health care costs. Since insurers are not allowed to discriminate on the basis of price, they will try to discriminate in other ways. In the attempt to avoid sick people — a game, like musical chairs — some will be more successful than others. The less successful will have higher costs, which will require higher premiums, which will result in fewer customers, etc.[57]

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

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

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

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

- If insurers are allowed to alter their benefit packages and genuinely compete (as the Heritage Foundation seems to advocate),[58] then healthy and sick people will gravitate to different plans and the plans with sicker subscribers will not survive.

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

Despite inherent problems, the proposal has been influential. It forms the basis for President Bush's health insurance reform proposal, Bill Clinton's proposal, a proposal developed by House Democrats [59] and proposals being considered in California,[60] Maryland[61] and other states.

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

Case Study: The Bush Plan. President Bush has endorsed a much-needed reform of our health care system: tax credits for people who purchase their own health insurance. Yet for many, the financial advantage of the tax credit would be more than wiped out by the effects of the president's plan for community rating [62] — a plan to be implemented at the state level. Moreover, other provisions of the proposal would assure that almost no healthy person would purchase health insurance.

Most proposals for guaranteed issue and community rating give healthy people at least some incentives to buy health insurance. For example, a typical provision is that preexisting conditions are not covered until after a 12-month waiting period. Thus people who purchase insurance *after* an illness occurs risk 12 months of medical bills before the insurer picks up the tab. The Bush proposal, by contrast, has no waiting period.

Page 22 of the President's "white paper" on health care reform policy proposes that hospitals be able to get patients insured when they enter the emergency room. Uninsured people would face no financial risk. They could get insurance coverage as they enter a hospital and drop it as they leave.[63] Apparently the White House failed to consider that under such a system only sick people would buy health insurance.

Case Study: The Clinton Plan.[64] Like George Bush, Bill Clinton is convinced that health insurers should be in the managed care business rather than the insurance business. So far, the Clinton plan is long on rhetoric and short on detail. Nonetheless, it clearly endorses guaranteed issue, community rating and competition among insurers based on their ability to manage care.

There are, however, important differences between the candidates' plans. Whereas Bush would make the purchase of health insurance voluntary, Clinton would make it mandatory — requiring employers either to purchase

insurance directly or to pay a tax and shift the responsibility to government.[65] (Both options, of course, are an alternative to paying wages.) Whereas Bush would grant special tax relief to low-income families, Clinton would not — presumably requiring low-income employees to purchase health insurance (through their employer) whether they could afford to or not.[66] Moreover, Clinton is firmly committed to global budgets — the practice of giving providers a fixed sum and forcing them to ration health care. Some of these concepts are discussed in greater detail below.[67]

Case Study: The Federal Employee Health Benefits Program (FEHBP). Almost anyone familiar with the health benefits program for federal employees knows that it is in desperate need of reform. This is the opinion of the Office of Personnel Management (OPM), which oversees the program, and of other analysts inside and outside of government. For example, a Towers, Perrin, Forster & Crosby study concluded that "fundamental legislative reform is urgently needed."[68] Nonetheless, the program is interesting for three reasons. First, over the past two decades reformers have called for a national health insurance program based on the FEHBP.[69] Second, the FEHBP is the model for the Jackson Hole approach.[70] And third, the FEHBP shows what can go wrong with the Jackson Hole approach.

"Despite the appearance of competition and the large number of HMO enrollees, the FEHBP has not succeeded in controlling costs."

The program has three main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans;[71] (2) government contributes a fixed amount that can be as much as 75 percent of each employee's premium; and (3) the plans are forced to community rate, charging the same premium for every enrollee. Despite the appearance of competition and the large number of HMO enrollees, the program has not succeeded in controlling costs:

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

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

One reason why the FEHBP has not held down costs is that deductibles in the fee-for-service plans are quite low. Even though most private employers are increasing their deductibles, Blue Cross's FEHBP "high-option" plan has a deductible of $200 and its "standard-option" plan has a deductible of $250. Why are the deductibles so low? Because OPM won't allow Blue Cross, or any other plan, to raise its deductibles or copayments. The reason? Other

things being equal, plans with greater patient cost-sharing are likely to attract younger, healthier employees. In fact, OPM rigorously reviews every tiny change in plan design to make sure that any attempt to taylor the plans to the needs of the employees does not appeal to good risks more than to bad ones. For example, it won't allow a plan to include coverage for teeth cleaning but omit coverage for dentures — on the theory that such a change would make the plan more attractive to young people.

"When insurers cannot price risk accurately, they try to compete for the good risks."

Even with this regulatory micromanagement, outside analysts say that virtually all the competition that exists is only competition for good risks — not competition in the sense in which Jackson Hole advocates imagine.[72] And it is precisely the adverse selection that results because insurers cannot price risk accurately that has caused Aetna, the only systemwide insurer other than Blue Cross, to leave the FEHBP.[73] Despite glowing descriptions by its defenders,[74] the FEHBP has none of the desirable characteristics of a competitive system:

- When competition is working, price reflects value; yet although there is a 42 percent difference in value of benefits between highest and lowest option plans, the premiums differ by 264 percent.[75]

- In order for competition to work, people have to be able to perceive differences or similarities in value; yet despite the fact that there is virtually no difference between the Blue Cross high-option and standard-option plans, many federal employees pay four times as much for the high option plan — believing incorrectly that they are getting four times more value.[76]

- Whereas workable competition should naturally lead to customer-pleasing innovations, none of the FEHBP plans are allowed to offer a Flexible Spending Account — a highly valued and common feature of private employer-provided health insurance.[77]

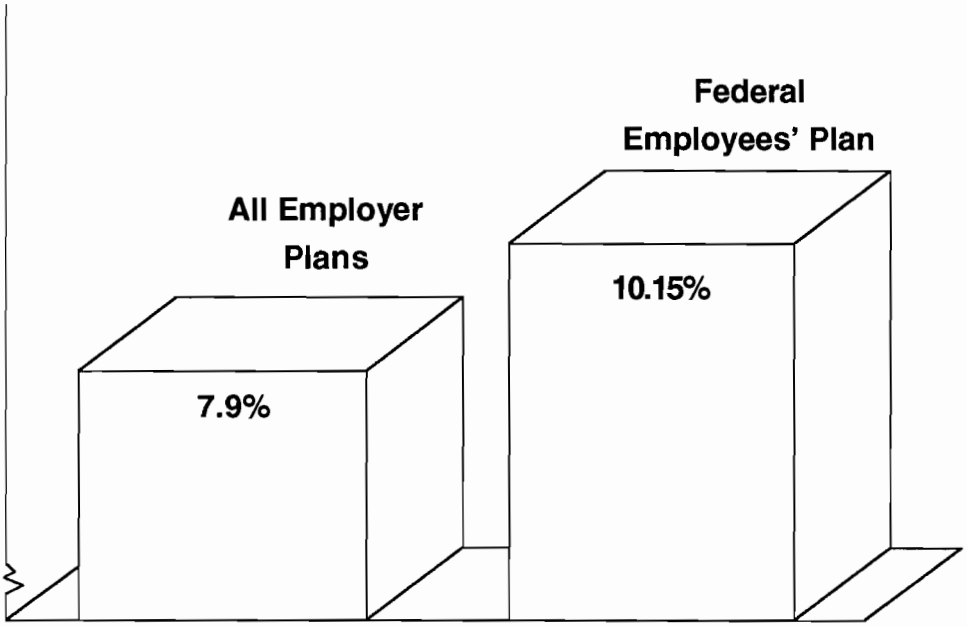
- Whereas the Jackson Hole Group imagined that insurers in such a system would compete based on their ability to manage care, the fee-for-service plans now instituting managed care are doing so not because they see it as good business, but because federal law requires it.[78]

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

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

FIGURE V

Annual Rate of Growth in Per Capita Health Care Costs[1] 1980-1990



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

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

Traditionally, "managed care" meant combining payment with provisions of health care — typically in a Health Maintenance Organization (HMO).[79] More recently, the term has been applied to a whole range of activities whose goal is to make medical care more cost-effective. In all its guises, managed care means interfering with the conventional doctor-patient relationship.

Most studies show that HMOs save money by substituting less expensive for more expensive therapies. For example, physician therapy and drug therapy are both less expensive than hospital therapy. The next generation of cost management techniques, however, seeks to subject *every* medical decision to cost-benefit analysis. For example, the American Medical Association and the Rand Corporation are working on "practice guidelines" for physicians, and Congress has mandated that the Department of Health and Human Services draw up similar guidelines. The goal is to develop "computerized protocols" that will tell physicians what to do when confronted with certain patient symptoms and conditions.[80]

Will the guidelines work? That's not clear. Many people believe they will be a waste of money. Some argue that their development is such a lengthy process that computerized protocols will always be years behind state-of-the-art medical practice. Others say that such protocols assume that computer programs will usually make better decisions than the physicians who meet and talk with patients. Though many physicians could benefit from properly designed protocals, in one test, judgments of general practitioners were matched with three different computerized protocols in the treatment of patients with abdominal pain; the GPs outperformed the protocols each time.[81]

"Most advocates of managed care envision a world in which a bureaucracy tells physicians and patients what to do."

Most advocates of managed care envision a world in which a bureaucracy tells physicians and patients what to do. The techniques of managed care form the basis of these instructions. Yet if the techniques had value, they might be adopted voluntarily in the marketplace. For example, if workable computerized protocols were available to physicians, they might be valuable tools. Physicians could consult the computer, then substitute their own judgments where appropriate. Less complicated protocols might be available for home computers, giving patients advice on whether to see a physician, for example.

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

If managed care is forced on people by government policy, it could threaten the quality of patient care. Unfortunately, the threat is real. Rand Corporation researcher Robert Brook has argued that Rand's techniques can be used to ration health care under the Medicare system.[82] And William Schwartz (Tufts) and Daniel Mendelson (Lewin-ICF) argue that managed care has already achieved most of the savings that are achievable by reducing hospitalization. The only way for managed care to control the long-term rise in health care costs, they argue, is to deny people access to expensive but useful technology.[83]

Problem: Insuring the Uninsured

In any one month, about 34 to 35 million people are uninsured, and the number appears to have increased over the past decade.[84] This is not a stable population, however. Although many people become uninsured during their lifetimes, few remain in that status for long periods. Only 30 percent stay uninsured for more than one year, and only 4 percent of the nonelderly stay uninsured for much longer than two years.[85]

"Only 4 percent of the nonelderly population stays uninsured for much longer than two years."

Why are so many people temporarily uninsured? The evidence suggests three reasons, which have been discussed above. First, the constraints of federal tax law and employee benefits law have made it increasingly difficult for small businesses to provide health insurance for employees. Second, although the federal tax law generously subsidizes employer-provided health insurance, there are few or no subsidies for individuals who purchase their own health insurance. Finally, state regulations are increasingly pricing lower-income, healthy people out of the market for health insurance.

What can state governments do?

Good Idea: Deregulate. As we shall see below, cost-increasing state government regulations are pricing as many as one out of every four uninsured people out of the market for health insurance. Regulations that increase the price of insurance include mandated benefits, risk pool assessments and premium taxes. In addition, as discussed above, an increasing number of states are imposing price controls — which have the effect of raising premiums for low-risk people in order to subsidize the premiums of high-risk people. The most straightforward way to lower the cost of health insurance for the vast majority of people is to deregulate.

Good Idea: Direct Subsidies. Another way to help lower-income families is through direct subsidies. As noted above, there is an urgent need to reform federal tax policy toward health insurance — redirecting $60 billion per year in federal tax subsidies from high-income to low-income families. Meanwhile, a number of state governments are seizing the initiative. For example, several states now exempt small business policies from state taxes levied on health insurance premiums, and at least six states extend tax credits to employers who are first-time buyers of health insurance. Iowa, for example, exempts "bare bones" policies from premium taxes and provides a tax credit to employers who pay at least 75 percent of the premium for low-income employees and half of the premium for the employees' dependents.[86] Premium taxes also have been waived for small businesses in Nevada, New Mexico and West Virginia. Other states that give employers tax credits for the purchase of health insurance include Kansas, Kentucky, Montana, Oklahoma and Oregon. The credit is $15 per employee per month in Oklahoma and up to $25 in Oregon.[87]

Bad Idea: Employer Mandates. Virtually all economists agree that fringe benefits are earned by workers and that they substitute for wages. Requiring employers to provide health insurance, therefore, is simply a disguised attempt to force workers to take health insurance rather than wages. The mandates nominally apply to employers. In reality they force workers to purchase health insurance, whether they want to or not.

There are two types of proposals to mandate employer-provided health insurance. One simply requires employers to provide insurance.[88] The other gives them a play-or-pay option — either to provide health insurance or pay a tax.[89] Both are far more regressive than proposals to offer tax subsidies to individuals. The mandates require workers to be able to produce enough to finance their own health insurance or go without a job. [See Table II.] Tax credits would give more help to those who need it most without interfering with job opportunities. More importantly, employer mandates are an unstable solution — one which would inevitably lead to national health insurance. [See the sidebar on Employer Mandates.]

"Virtually all economists agree that fringe benefits are earned by workers and that they are a substitute for wages."

Bad Idea: Individual Mandates. If a fair system of tax credits for the purchase of health insurance were instituted, there would be no need to mandate anything. People who did not purchase health insurance would pay higher taxes. The higher taxes would be used to pay for uncompensated care for the uninsured, after they exhausted their own resources. Nonetheless, the Heritage Foundation proposes to *force* individuals to purchase health insurance.[90] The trouble is that mandated health insurance would likely be similar to mandated auto liability insurance in California, Massachusetts and New Jersey. [See the sidebar on Individual Mandates.] And like employer mandates, individual mandates would create irresistible pressures for government to keep down the price of health insurance by regulating the entire health care system.

Worst Idea: National Health Insurance. National health insurance would be comparable to enrolling everyone in the Medicaid program. Inevitably it would lead to health care rationing and waiting lines. [See the sidebar on Canada's global budgets.] In other English-speaking countries with national health insurance, the central question is: How easy is it to get out of the system and take advantage of private sector medicine?

- Although health care is theoretically free to all in England, 10 percent of the population has found it necessary to purchase private health insurance with aftertax income.[91]
- In New Zealand, one-third of all families have private health insurance and one-fourth of all surgeries are performed in the private sector.[92]
- Although private health insurance has been effectively outlawed in Canada, an increasing number of Canadian patients are crossing the U.S. border to get health care they cannot get in Canada.[93]

Case Study: The Massachusetts Plan. In the 1988 presidential campaign, Michael Dukakis claimed that he had provided health insurance for

everyone in Massachusetts. In fact, the mandate for employers was not scheduled to take effect until 1992. Before that could happen, the state legislature postponed it until 1995, and it may never be implemented. Governor William Weld has argued that it would devastate the struggling Massachusetts economy.[94]

This early attempt at play-or-pay legislation would have required Massachusetts employers to provide health insurance for their employees or pay a tax of 12 percent on the first $14,000 of wages. Other provisions in the bill would have required college students to carry health insurance and attempted to expand access for the poor and uninsured, in part through a state-subsidized insurance program.[95]

"Mandates require workers to produce enough to finance their own health insurance — or go without a job."

TABLE II

Estimates of the Number of Lost Jobs Caused by Employer-Mandated Health Insurance

Estimate	Jobs Lost
National Center for Policy Analysis[1]	**1,100,000**
Employee Benefit Research Institute[2]	**200,000 — 1,200,000**
Joint Economic Committee[3] (Republican Staff)	**710,000 — 965,000**
Pioneer Institute[4]	**358,000**

[1]Estimate of the effects of the Kennedy bill (S. 768). See John C. Goodman, Aldona Robbins and Garry Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1989.

[2]Estimate of the cost of an employer mandate, assuming the cost per employee ranges from $970 to $2,430. See William S. Custer and Jill Foley, "Health Care Reform: Tradeoffs and Implications," Employee Benefit Research Institute, *EBRI Issue Brief,* No. 5, April 1992.

[3]Estimate of the cost of a play-or-pay mandate, with 7 percent and 9 percent "pay" options. See Joint Economic Committee, Republican Staff, "Run From Coverage: Job Destruction from a Play or Pay Mandate," Health Care Briefing Paper No. 5, April 9, 1992.

[4]Estimate of the effects nationwide of the Dukakis play-or-pay mandate. Based on Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?* (Boston: Pioneer Institute for Public Policy Research, 1988). Reported in Goodman, Robbins and Robbins, "Mandating Health Insurance."

What's Wrong with Employer Mandates?

Under a typical play-or-pay plan employers would be given a choice: provide health insurance to employees or pay a tax and let the government provide the insurance. Regardless of the specifics, all such plans would have four bad consequences. They would (1) impose a regressive tax burden on low-income workers, (2) cause a loss of jobs, (3) encourage public rather than private health insurance and (4) inevitably lead to national health insurance.

Regressive Taxes. Play-or-pay plans would have virtually no effect on large companies, which already provide health insurance, or on high-income employees, most of whom are already insured. The plans would have a major impact on small business and low-income employees. The inevitable result is loss of jobs and lower take-home pay.

Loss of Jobs. The Urban Institute estimates that a national play-or-pay plan would impose a $36 billion cost on employers and create an additional $30 billion cost for government (probably to be paid by additional taxes on employers and employees). Estimates of the number of people who would lose their jobs range from 710,000 (for a 7 percent pay option) to 965,000 (for a 9 percent pay option).

Why Pay Is More Attractive than Play. Suppose employers have the option to pay a 7 percent tax or provide health insurance. Considering that about 95 percent of all uninsured workers earn less than $30,000 a year, most of their employers would have strong incentives to pay the tax and forget the problem. William Dennis (NFIB Foundation) has calculated that almost all small businesses would pay rather than play. According to the Urban Institute, under a 7 percent play-or-pay option, 84.2 million workers and their dependents would fall under the government plan. Overall, *three-fifths of the entire population* would be insured by the federal government.

Opening the Door to National Health Insurance. Play-or-pay plans are inherently unstable. If the tax remains fixed, more employers will unload workers onto the government plan as the cost of health insurance rises. If the tax increases, there will be more unemployment and more unemployed people on the government plan as the cost of health insurance increases. Either way, the number of people covered by the public sector will rise.

Sources: Sheila Zedlewski, Gregory Acs, Laura Wheaton and Colin Winterbottom, "Play or Pay Employer Mandates: Potential Effects on Insurance Coverage/Costs," The Urban Institute, January 8, 1992; William J. Dennis, "Taxes Based on the Inability to Pay: Another Effect of 'Play or Pay'," NFIB Foundation, October 1991; Joint Economic Committee, Republican Staff, "Run from Coverage: Job Destruction from a Play or Pay Mandate," Health Care Briefing Paper No. 5, April 9, 1992; Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription*? (Boston: Pioneer Institute for Public Policy Research, 1988); and John C. Goodman, "Health Insurance: States Can Help," *Wall Street Journal,* December 7, 1991.

What's Wrong with Individual Mandates?

In almost every state people are required to buy auto insurance as a condition for the right to drive. Many — including some who otherwise advocate free market solutions to health care problems — have argued that health insurance should be mandatory, in an analogous way. How well would that work?

Case Study: Automobile Liability Insurance. Massachusetts has the highest automobile insurance premiums in the nation. It also has the highest rate of auto insurance claims. One reason is that Massachusetts subsidizes bad driving through artificially low insurance rates. Under Massachusetts law, insurers are forbidden to base their premiums on age, sex or marital status. Insurers are required to sell policies to almost any driver, and they cannot charge higher premiums for policies transferred to the state's high-risk pool. As a result, about 94 percent of young male drivers and 82 percent of young female drivers are in the risk pool. As a proportion of all premiums, policies assigned to the risk pool soared from 23 percent of the market in 1977 to 65 percent in 1989.

Whereas nationally only about 8.3 percent of auto insurance premiums represent high-risk pool insurance, the Massachusetts risk pool now accounts for one-fifth of all the auto risk pool insurance in the United States. The risk pool invariably loses money, and the deficits are financed by higher premiums charged to other drivers. Overall, there is little relationship between driving behavior and insurance premiums in Massachusetts.

Similar problems are occurring in California and New Jersey.

Proposals to Treat Health Insurance Like Auto Liability Insurance. If individuals were required to purchase health insurance, health insurance prices — like auto liability insurance prices — would be determined in the political arena. Moreover, because health insurance is a far more emotional issue than auto liability insurance, the experience of Massachusetts and other states is only a small indication of the political crisis that would be created.

Opening the Door to National Health Insurance. Realistically, the federal government cannot require the purchase of health insurance and leave insurers, providers and state legislators free to increase the price without limit. Mandating health insurance is an open invitation to federal regulation of the entire health care system.

Sources: Simon Rottenberg, *The Cost of Regulated Pricing: A Critical Analysis of Auto Insurance Premium Rate-Setting in Massachusetts* (Boston: Pioneer Institute for Policy Research, 1989); and John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

Although the intent of the bill was to make health care "universal" and affordable within the state, only college students would have been required to have health insurance. And perversely, more people might become uninsured if the program were fully implemented. Since the maximum tax would be $1,680 per employee (the "pay" option), and since health insurance is likely to cost much more than that, many employers would find it cheaper to pay than to play.[96] As employers dropped health insurance, opting to pay the tax instead, many employees — those who are young and healthy — would be unlikely to purchase a state-sponsored health insurance policy, even at subsidized prices.

"Under the Massachusetts plan more people might become uninsured."

If enacted, the Massachusetts plan would be especially harmful to small businesses. In a study for the Boston-based Pioneer Institute, economists Attiat Ott and Wayne Gray found that the Dukakis plan would force Massachusetts businesses to increase spending on employee health insurance by at least 32 percent. Because of the increased cost of employing workers, as many as 9,000 jobs would be lost, with the lowest paid workers being the hardest hit.[97]

Case Study: The Hawaii Plan. Proponents of a universal system of health insurance have pointed to the Hawaii Plan as a model for other states, noting that some 98 percent of Hawaiians are covered by health insurance compared with only 85 percent of nonelderly Americans as a whole. Proponents also claim that even with a near-universal system, Hawaii's medical costs and insurance premiums have been rising more slowly than in other states. Let's take a closer look.

In 1974 the state of Hawaii enacted the Prepaid Health Care Act, requiring employers to provide health insurance for all employees working over 20 hours a week. Although the Supreme Court invalidated the law in 1981, declaring its application to self-insured companies to be in violation of the Employment Retirement Income Security Act, Hawaii got an ERISA exemption from Congress.[98] Those not covered by the law — employees working fewer than 20 hours a week, government employees, small family businesses, the unemployed and seasonal workers — or not covered by Medicaid are covered by a program established in 1989 known as the State Health Insurance Plan (SHIP).[99]

One reason why Hawaii has had fewer problems than other states could expect is that the state's population is apparently healthier and medical costs are much lower. The state's extensive network of HMOs probably contributes to the state's ability to contain health care costs. And a tradition of employer-provided health care means that the state mandate may not be changing the behavior of many people. For example, by one estimate, only

5,000 additional people — out of a population of over a million — acquired health insurance as a result of the employer mandate.[100] Moreover, employer-provided health insurance is usually much more generous than the minimum benefits required by the state and employers usually cover workers' dependents, even though they are not required to.[101] Generalizing from Hawaii's experience to places where many employers are not now providing health insurance would be a mistake.

It would also be a mistake to conclude that those who are not covered by employer plans receive comparable benefits under the state plan. SHIP is much more limited in its coverage than the employer-based insurance. For example, it covers only five days in the hospital and only 12 physician visits.

In addition, Hawaii is made up predominantly of small businesses, many of which avoid hiring employees in order to avoid paying the cost of health insurance. This practice may have affected the state's economic performance in the decade following the enactment of the program. In the 1980-86 period, the state's employment grew by only 9 percent, compared with 13 percent for the nation and 20 percent for the U.S. Pacific Coast states. Another cost is reduced money wages. In 1975, when the law first went into effect, Hawaii was 25th among the states in average annual employee wages. By 1986 it had fallen to 36th.[102]

Problem: Insuring the Uninsurable

If policies were guaranteed renewable and portable, people would have strong incentives to become insured before they got sick. But what about people who are already sick and uninsured and are generally thought to be uninsurable?

Best Idea: Direct Subsidies. The best approach is to subsidize directly people who are uninsurable, making the amount of subsidy highest for those with lowest incomes. The subsidies should be funded by general taxes. Government might pay a portion of their medical bills — say, everything above 30 percent of income — or part of the cost of having an insurer manage their health care. A less attractive option is to subsidize premiums for these people to join a risk pool. But even this option is much better than proposals to impose price controls and force insurers to sell policies to sick people at artificial premiums.

"The best approach is to subsidize directly people who are uninsurable, making the amount of subsidy highest for those with lowest incomes."

Mediocre Idea: Create Risk Pools. One way in which state governments have attempted to provide health insurance for high-risk individuals is

through risk pools. Currently 27 states have passed legislation creating risk pools.[103] Under this arrangement, insurance is sold to individuals who cannot obtain policies outside of the pool. Premium prices are regulated and generally are set as a percentage of the prices of similar policies sold in the marketplace. For example, in most states the premium for risk pool insurance is 50 percent higher than for comparable policies.[104] In Florida, however, risk pool premiums may be three times as high, and in Montana they may be four times as high. In Minnesota, the most generous state, risk pool insurance is only 25 percent more expensive.[105]

Since all states cap the price of risk pool insurance (thus creating an artificially low price), risk pools almost always lose money.[106] In most cases, losses are covered by assessing insurers — usually in proportion to their share of the market. However, in Maine, losses are covered by a tax on hospital revenues. In Illinois and California, the subsidies are funded by general tax revenues.[107] The most common approach is to assess participating insurers in proportion to their share of the state health insurance market. In many states that assess insurers for risk pool losses, companies are allowed to fully or partially offset their assessment against premium taxes paid to state governments.[108]

"One problem with most risk pools is that they raise the cost of health insurance for everyone not in the pool."

Precisely because risk pools lose money and because there is a natural resistance to the higher taxes needed to fund these losses, many states refuse to sell risk pool insurance to all who would like to buy it. In Illinois, for example, the price is kept artificially low, but there is a waiting list of potential buyers. An extreme case is Texas, which has a risk pool but no funding — and therefore no policyholders.

The most serious problem with risk pools is that they raise the cost of health care and/or health insurance for everyone not in the pool. When risk pool losses are paid by a tax on hospital revenues, the burden is placed on sick people. When losses are covered by assessing insurers, the burden is placed on other policyholders. And when insurers are allowed to offset their assessments against state taxes, additional pressure to maintain (or even increase) taxes on insurance premiums is created and causes further distortion in the health insurance marketplace.

In general, risk pools cause the least distortion if they are funded with general tax revenues and if the subsidies are based on the policyholder's ability to pay. [See the discussion below on paying for health care reform.]

Worst Idea: Regulating All Insurance. As noted above, less than 1 percent of the nonelderly population is uninsurable. Yet some misguided reformers would impose price controls and other regulations on the other 99

percent in order to solve the problems of a tiny minority of people. As we have seen, guaranteed issue is one example. Community rating is another. In all cases, the social cost of the "reform" far outweighs the social benefit.

Problem: State Regulations

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

"Government regulations are pricing as many as one out of every four uninsured people out of the market for health insurance."

Mandated benefits laws cover diseases ranging from mental illness to alcoholism and drug abuse, services ranging from acupuncture to in vitro fertilization, and providers ranging from chiropractors to naturopaths. They cover everything from the serious to the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and deposits to a sperm bank in Massachusetts. As Figure VI shows, in 1965 there were only eight mandated health insurance benefits laws in the United States. Today, there are more than a thousand.[109]

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

- According to one study, mandated coverage increases premiums by 6-8 percent for substance abuse, 10-13 percent for outpatient mental health care and as much as 21 percent for psychiatric hospital care for employee dependents.[110]

- According to another study, one out of every four uninsured people has been priced out of the market by state-mandated benefits laws.[111]

In addition to mandates, private insurance is burdened by premium taxes, risk pool assessments and other regulations. As noted earlier in this study, most large corporations are exempt from these regulations because they self-insure. The full weight of such regulations falls on the most defenseless part of the market: the self-employed, the unemployed and the employees of small businesses.

Good Idea: Total Repeal of State-Mandated Benefits. The most straightforward way to lift the burden of state mandates is to repeal them. As noted below, a number of states have already repealed mandates for small businesses. But if mandates are bad for small businesses, why aren't they also bad for other businesses? There is no reason to substitute the judgment of politicians for the judgment of buyers and sellers in determining the extent of health insurance coverage.

Good Idea: Allow No-Frills Alternatives. Failing total repeal of mandated benefits, state governments should allow insurers to sell a no-frills policy to any buyer within the state. Mandate-free insurance could compete side-by-side with regulated insurance. This would extend to the rest of the population a right now enjoyed only by employees of the largest corporations.

Second-Best Idea: Exempt Small Businesses. At one time it was thought that significant progress could be made in exempting small businesses from mandated benefits. Over the past few years, 24 states have done so to one degree or another.[112] Take Washington state, for example. Normally, health insurance policies there would be subject to 28 mandates — covering alcohol and drug abuse, mammography and the services of chiropractors, occupational therapists, physical therapists, speech therapists, podiatrists and optometrists. Under a law passed in 1990, firms with fewer than 50 employees can buy cheaper insurance with no mandated benefits.

"There is no reason to substitute the judgment of politicians for the judgment of buyers and sellers in determining the extent of health insurance coverage."

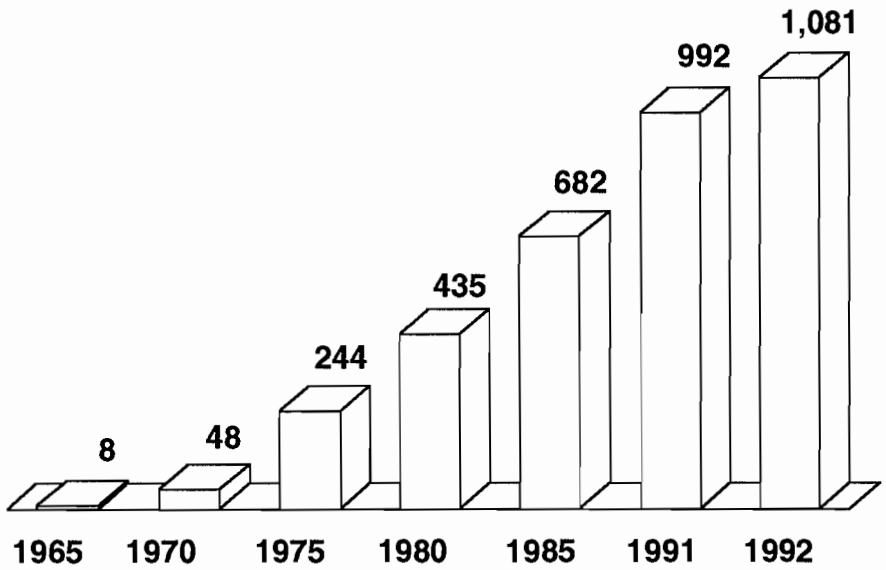
While a step in the right direction, most mandate-exemption laws are so narrowly constructed that the qualifying firms are few and dispersed. Unable to identify a large enough market, most insurers have simply ignored it. For example, in 14 states such exemptions apply only to firms with no more than 25 employees. In addition, many states allow a small business to qualify only if it has been without insurance for some period of time. In seven states the qualifying period is at least one year; in Kansas, Maryland and Rhode Island, two years; and in Kentucky, three years. In these states, small employers who currently provide insurance coverage are penalized for doing so. All the benefits from the new legislation go to their uninsured competitors.[113]

Second-Best Idea: Social and Financial Impact Statements. Following the lead of Washington, Arizona and Oregon, more than a dozen state legislatures now require social and financial impact statements before they will pass additional mandates.[114] For example, because of concern about costs, in 1983 Washington state began putting the burden of proof on mandate proponents to show that its benefits exceed its costs. As a result, no new

FIGURE VI

Number of Mandated Health Insurance Benefits Enacted by State Governments

(1965 to 1992)



Source: Greg Scandlen, *Health Benefits Letter,* Vol. 1, No. 15, August 29, 1991, and Vol. 2, No. 2, July 31, 1992.

"The number of state mandates soared in the 1970s and 1980s."

mandates have been adopted by the Washington legislature for several years.[115] Clearly, impact statements slow the passage of mandated benefits, if only because the proponents of mandates need more time and money to overcome the new legislative hurdles.

Problem: Meeting the Needs of Underserved People

It is widely believed that certain groups of people are being underserved by the U.S. health care system. They include (1) low-income families, (2) uninsured people and (3) those who live in rural areas.[116] The following proposals meet the needs of these people innovatively — not by spending more money but by using current funds more effectively. Some of the proposals would require waivers from the federal government, but the Bush administration has indicated a willingness to grant waivers for innovative solutions.

Good Idea: Medical Enterprise Zones. In certain areas of the country, especially rural areas, the number of doctors and hospital beds per

Alternatives to Mandated Benefits

In many, perhaps most, cases, mandated benefit laws merely represent the legislative success of special interests. However, in other cases they address issues that many people care about: preventive care, well-child care, maternity expenses, medical expenses for adopted children, medical expenses for AIDS patients, etc. Legislators often mandate these benefits out of a desire to remove financial barriers to health care or to relieve families of financial burdens.

Even if the goal is humane and desirable, the method is not. In passing mandated benefit laws, state legislators are attempting to create benefits without paying for them. The cost is then imposed on other people through high health insurance premiums. When legislators attempt to benefit one group, they raise the cost of insurance for another.

The result is a redistribution of costs and benefits that usually is highly regressive. Those most likely to gain are special groups of middle-income families. Those most likely to lose are lower-income families who are priced out of the market for health insurance as premiums rise to cover the cost of the new mandates.

Direct Subsidies. A more efficient and humane way to accomplish the same objectives is through direct subsidies funded by general tax revenues. State governments, for example, could make direct payments to low-income families with particular health disabilities. The payments could be income-related so that financial help is targeted to those who need it most. Another technique is to subsidize purchases of particular medical services (such as prenatal care), again with the subsidies targeted to low-income families. A third strategy is to directly subsidize the health insurance premiums of people with particular disabilities (such as AIDS), based on their income.

Each of these alternatives allows the health insurance marketplace to continue to function — allowing people options among different types of coverage and allowing premiums to reflect the real cost of the options. Each alternative also requires legislators to pay for the benefits they confer and makes it more likely that the subsidies will go to people who most need them and that the costs will be borne by those who can best afford them.

Individual Self-Insurance. Apart from more expensive medical services, there is a trend toward state mandates for relatively inexpensive preventive services such as pap smears, mammograms and well-child care. The vast majority of people can budget and pay them out-of-pocket. Some legislators are concerned that when family budgets are tight, people will skimp on medical care. Yet the evidence suggests that using insurers to pay small medical bills is costly and inefficient. A better solution is to encourage people to establish and use Medical Savings Accounts for small medical bills.

Source: 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.

capita is well below the average for the country as a whole. These areas are often called "underserved." The people who live in them are not necessarily deprived of medical care. They can travel to a neighboring area that is not underserved. But the cost and inconvenience of travel may be burdensome, especially for low-income patients. Overall:[117]

- In 1988, 111 rural counties in the United States had no physician.
- About half a million rural residents live in counties with no physician trained to provide obstetric care and 49 million in counties with no psychiatrist.
- Although hospitals are closing in most parts of the country, rural hospitals are closing at twice the rate of urban hospitals.

"Medical Enterprise Zones give underserved areas the freedom and flexibility to meet health care needs with scarce resources."

Many people assume that the only way to meet the health care needs of rural citizens is to spend more government money on rural health care programs. In fact, current government programs and policies are probably a far greater obstacle to good quality care at a reasonable price than a lack of funds.[118]

In most states, medics who treated soldiers in the field in the Vietnam or Persian Gulf wars are not allowed to treat ordinary citizens, even if no doctor lives in the area. The same restrictions apply to nurses and physicians' assistants, despite studies showing that paramedical personnel can deliver certain kinds of primary care as well as licensed physicians.[119]

Many state and federal regulations discriminate against rural areas in other ways by placing onerous, cost-increasing restrictions and regulations on health care providers and facilities. These regulations often cause existing facilities to close and prevent new facilities from opening. [See the sidebar on the Case for Medical Enterprise Zones.]

The concept behind Medical Enterprise Zones (MEZs) is that underserved areas should have the freedom and flexibility to make their own decisions about the best way to meet health care needs with scarce resources. Accordingly, within MEZs, many of the normal restrictive rules and regulations would be suspended, creating new options and opportunities for the people who live there.[120]

Good Idea: Medical Enterprise Programs. Closely related to the MEZ is the concept of Medical Enterprise Programs (MEPs). Whereas an MEZ is defined in terms of a geographical area, an MEP is defined in terms of

a market being served. The urban poor often face many of the same problems as rural residents — not because of a lack of physicians and facilities, but because they have been priced out of the market by government regulations that have resulted from special-interest pressures. Accordingly, providers and facilities providing medical services primarily to low-income families should be allowed to participate in Medical Enterprise Programs that are exempted from many government regulations in a manner similar to those in an MEZ.

Good Idea: Decentralized Medicaid. One of the biggest problems with the Medicaid program is that the decision makers who write the rules and regulations are often far removed from the problems they are attempting to solve. Politicians, pressured by special-interest groups, decide who is eligible and who is not, and in many ways dictate how health care is to be delivered. Often, their decisions result in an enormous waste of resources and prevent local communities from solving problems in a reasonable way. The regulations governing nursing homes is an example.

Almost all people involved in indigent health care can suggest better ways of spending health care dollars, were it not for federal and state regulations. They should have the opportunity to implement their suggestions. Medicaid funds should be turned over to local communities with only one caveat: that the funds be spent on indigent health care. This would give the local people who actually have to solve problems the freedom to decide who is eligible for assistance and what type of health care is appropriate.

Best Idea: Community-Centered Welfare. Given limited resources, it is not obvious how much money should be spent on physicians and hospitals rather than on housing, food, and other goods and services. Currently, those decisions are made by politicians who govern what we loosely call the welfare state. Better decisions are likely to be made by people in local communities faced with real problems. Accordingly, we propose that all means-tested welfare spending be turned over to local communities with only one restriction: that funds be spent to help low-income people. Under Community-Centered Welfare (CCW), the amount given by federal and state governments would not be determined by arbitrary eligibility standards devised in the political process. Instead, the amount of CCW funds each community receives would be solely a function of the amount and degree of poverty in that community.

"All means-tested welfare spending should be turned over to local communities."

Good Idea: Medicaid Waivers. All of the proposals in this section would require a fundamental change in the Medicaid program. But many needed changes might be accomplished through administrative waivers —

The Case for Medical Enterprise Zones

Rural areas often suffer from a shortage of health care providers and facilities. This is a result, in part, of expensive and burdensome government regulations. For example:

- Medicare rules require rural hospitals to maintain a staff of numerous professionals (whether needed or not), including a full-time director of food and dietary services.
- State licensing laws often require rural hospitals to have fully equipped operating rooms and a surgical staff — even if the hospital performs no surgery.
- Medicare requires hospitals to meet expensive fire and safety rules, including corridors of a minimum width — even if the rural hospital is greatly underused.
- State licensing laws often require hospitals to employ several individuals to perform tasks that one person could perform.
- In order to qualify as a Community Health Center (CHC), a facility must have a minimum number of patient encounters per physician, and administrative costs must not exceed a certain percent of total costs — standards that many rural CHCs cannot meet.
- Medicare and Medicaid regulations prevent hospital-physician joint ventures, physician ownership of hospitals and other arrangements that might induce more physicians to practice in rural areas.

The general principle behind the concept of Medical Enterprise Zones (MEZs) is that some care is better than none. People who live in areas where care is unavailable or difficult to deliver should have the opportunity to have their area classified as a community MEZ. Within MEZs, many restrictions — such as those listed above area — would be waived.

For example, numerous studies have shown that qualified nonphysicians can render many medical services traditionally provided by physicians — and at a lower cost. Collectively referred to as "mid-level practitioners," they include nurse practitioners, physicians' assistants, certified nurse-midwives, certified registered nurse anesthetists and paramedics. State laws also restrict such personnel as pharmacists, optometrists and various technicians and therapists. These restrictions would be relaxed in an MEZ.

Given the poor economic conditions in many rural areas, health care professionals should be permitted to own pharmacies, laboratories, hospitals and home health services in which they have a financial interest. Health care professionals would be required to inform patients that they have a financial interest in a facility or service, and inform them of other, competing facilities or services, but Medicare, Medicaid and state legislation could not prohibit them from referring rural patients to facilities in which they have a financial stake.

Finally, Medicare and Medicaid should reimburse MEZ providers at the same rates paid in other areas — ending current discriminatory practices. For example, the average payment that Medicare made to hospitals was 9 percent greater for large city hospitals than for rural hospitals in 1989. Medicare's method of paying physicians relies on "customary, prevailing and reasonable charges," which means more expensive urban doctors tend to receive about 36 percent more for the same service.

Source: John C. Goodman and Gerald L. Musgrave, "National Health Insurance and Rural Health Care," National Center for Policy Analysis, NCPA Policy Report No. 107, October 1991.

which do not require new legislation. Although Medicaid for a time was reluctant to grant waivers, over the past decade it has been more open to state innovation.[121]

"Federal tax dollars help pay the medical bills of an $11,000-a-year family in Alaska, while help is denied to a $2,000-a-year family in Alabama."

Case Study: What's Wrong with Medicaid? At its inception in 1965, proponents claimed that the Medicaid program would provide the poor with expanded access to medical care, which would in turn save on future costs. No one today believes Medicaid has lived up to those early expectations. Though program funding has increased significantly, the number of recipients has not increased proportionately.[122]

- In 1980, for instance, more than 21.5 million Medicaid recipients received $23.3 billion in benefits.
- By 1988, though only 1.7 million recipients had been added to the rolls, spending had more than doubled to $48.7 billion.

Currently, Medicaid covers only about half of nonelderly people living in poverty.[123] Even so, Medicaid spending is expected to absorb one-fourth of state budgets by 1995.[124] [See Figure VII.]

On average, about 60 percent of Medicaid expenses are paid for with federal tax dollars.[125] And one of the strangest features of Medicaid is the way in which federal dollars are spent. For example:[126]

- In Alaska, federal tax dollars help pay the medical bills of a family of three on Aid to Families with Dependent Children (AFDC) with an income of $11,076.
- But since the threshold for a comparable family in Alabama is only $1,788, the family would be denied help if their income were, say, $2,000.

The services paid for by Medicaid also differ considerably from state to state. Although the federal government mandates certain services, the states add on a variety of options, including the services of chiropractors, optometrists and podiatrists, and devices such as dentures, prostheses and eyeglasses. Although many below-poverty-level families are denied coverage for basic medical care in some states,[127]

- Medicaid patients are entitled to the services of chiropractors in eight states, dentures in eight states and eyeglasses in 16 states.
- In one state they are entitled to the services of Christian Science nurses, and in four states patients may enter Christian Science sanitariums.

Clearly, the federal taxpayer's dollars do not go first to those who are most in need nor are they spent first on those services which meet the most important medical needs.

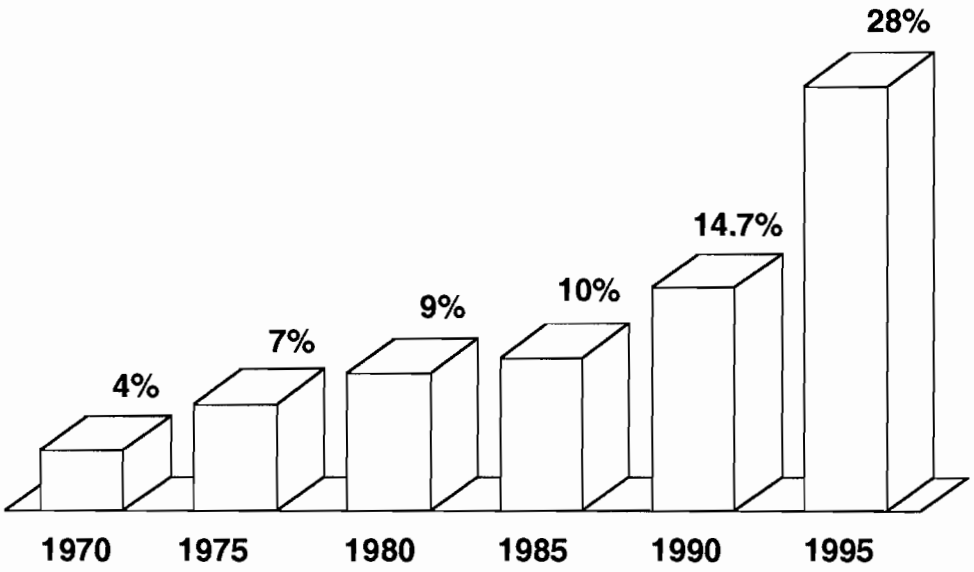
In principle, people on Medicaid are entitled to virtually any services covered by the program. In practice, patient care is rationed by Medicaid reimbursement practices. In most states, Medicaid payments for medical services are well below the payments made by other third-party payers. And Medicaid patients cannot add to Medicaid reimbursements with their own funds. For example:[128]

- In only four states is the Medicaid payment as high, or higher than, the payment made by Medicare.
- In New York, the Medicaid payment is only 30 percent of the Medicare payment, and in West Virginia it's only 35 percent.

"By 1995 Medicaid is expected to absorb over one-fourth of state budgets even though it serves only half the poverty population."

FIGURE VII

Growth in Medicaid Spending as a Percentage of State Budgets



Source: National Association of State Budget Officers.

- As a result, many physicians who used to accept Medicaid patients no longer do so and those who do may deliver a lower quality of care.

A similar phenomenon is occurring in the hospital and nursing home industries.[129]

- According to the American Hospital Association, Medicaid paid more than 90 percent of the cost of hospital care for Medicaid patients in 1980.

- By 1988, that figure had dropped to 78 percent. One consequence is that many hospitals no longer want to accept Medicaid patients.

"Although people on Medicaid are entitled to any service covered by the program, in practice health care is rationed because of reimbursement practices."

Things would be even worse were it not for the intervention of the federal courts, which are somewhat insulated from political pressures. In response to lawsuits filed by nursing homes in 20 states and hospitals in 21 states, the courts are ruling that Medicaid payments do not meet the standards of "reasonable and adequate" compensation and are ordering higher reimbursement levels.[130]

In principle, there is nothing wrong with paying lower prices in return for taking a hospital bed when it becomes available, rather than paying top dollar for immediate services. The trouble is that these decisions are being made not by patients but by the health care bureaucracy. The principal customer of medical providers is not the patient, but Medicaid, which, through its policy of setting reimbursement rates, increasingly determines the type and quality of care that Medicaid patients receive.

Case Study: Oregon's Rationing Program. In 1987 the Oregon legislature decided to cancel Medicaid funding for about 30 organ transplant recipients so that the state could expand services to poor women and children and still balance the Medicaid budget.[131] Since then, the state has been openly advocating health care rationing.

A ranking of medical treatments in terms of priority takes into consideration such factors as costs, benefits to the patient, the extent to which treatment would affect the patient's quality of life and community values.[132] The list of 709 procedures was established by a first-of-its-kind public process that included public hearings, community meetings and telephone surveys. The legislature cannot change the order on the list. It can only determine where on the list to draw the line and cease funding (currently after item 587).

Medical conditions considered "economically worthwhile" include prenatal care, several types of pneumonia, appendicitis, hernia and tuberculo-

sis. Conditions not covered include those which individuals can treat themselves, such as superficial wounds; benign conditions such as a cyst on the kidney; conditions that are untreatable such as anencephaly (a child born without a brain); and conditions that have a low success rate such as treatment for extremely low-birth-weight babies (less than 1.1 pounds and less than 23 weeks of gestation) and terminal AIDS patients.[133]

Proponents argue that the plan makes open and explicit rationing decisions that are being made covertly under the present system. Critics argue the plan unfairly reduces care for the young, the elderly and those with terminal illnesses such as AIDS.[134] The Department of Health and Human Services rejected the Oregon Health Plan on the grounds that it might conflict with the Americans with Disabilities Act.[135]

If we tried to meet every health care need, we could easily spend the entire gross national product on health care. As a consequence, we must choose between health care and other uses of money. One benefit of the Oregon plan is that it draws our attention to this uncomfortable fact.
The plan also invites us to consider alternatives. If government controls our health care dollars, then government must make the rationing decisions. If people control their own health care dollars, they can make their own rationing decisions.

Problem: Controlling Costs

Joseph Califano, former Secretary of Health, Education and Welfare (now the Department of Health and Human Services), has estimated that one out of every four dollars spent in our health care system is wasted.[136] Robert Brook of the Rand Corporation maintains that "perhaps one-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without."[137] But like waste in government, waste in health care is not tagged for easy identification. What is wasteful to one person is not necessarily wasteful to another. And waste has its own constituency.

"With competitive markets, 250 million Americans would have a self-interest in eliminating waste."

Good Idea: Use Markets. Virtually the entire world has come to realize that markets are powerful tools for encouraging efficiency. With competitive markets, 250 million Americans would have a self-interest in eliminating waste. Buyers would patronize low-cost providers. Providers would search for low-cost methods of delivering services. As noted above, creating Medical Savings Accounts which empower patients is probably the single best step towards market-based solutions. [See sidebar on Making Markets Work.]

Good Idea: Deregulate. Standing in the way of the use of markets are numerous legal barriers to competition. Take certificate-of-need (CON) laws, for example. Encouraged by the federal government in the 1970s, these laws require permission from government before a new hospital may be opened or an expensive piece of medical equipment purchased. They tend to protect existing suppliers against potential competitors by raising barriers to market entry. Although many states have eliminated these regulations, they remain an anticompetitive force elsewhere.[138]

Another anticompetitive force is legislation that limits the ability of third-party payers to engage in managed care. As noted below, there is not much evidence that managed care saves money, except on the most expensive procedures. But whether managed care works or not should be determined by the market, not by politicians. Unfortunately, too many special interests in the health care industry are unwilling to allow the market to work. In 1991, for example, 195 pieces of state legislation were introduced to stop, or cripple, managed care and other cost-control techniques.[139]

"There is not much evidence that managed care saves money, except on the most expensive procedures."

Among laws currently on the books, one in Indiana requires that Preferred Provider Organizations (PPOs) accept any physician willing to join. Thus Indiana Bell's PPO includes every physician in the state. Montana and Oklahoma have adopted similar measures. In some states hospital and physicians' groups are supporting legislation that would (1) require all utilization review to be done by local providers, (2) mandate that utilization review firms remain open 24 hours a day and (3) require state-specific statistical reporting. Such legislation would raise the cost of utilization review and inhibit its aggressive application. In addition, some states (including Texas) restrict the discount that insurers can give to patients who choose PPO doctors.

Good Idea: Reform the Tort System. No one knows exactly how much the tort liability system adds to an average medical bill. Most people think the number is quite large. Apart from measurable items (such as attorney's fees, court costs, damage awards and settlement checks), there are thousands of unseen ways in which the tort system affects costs. Out of fear that adverse medical events will trigger a lawsuit, for example, physicians order extra tests, perform extra procedures, and otherwise practice defensive medicine. The American Medical Association estimates that $5.6 billion is being spent each year on insurance premiums to protect doctors from lawsuits and another $15 billion is spent annually on defensive medicine tactics.[140] Other estimates place the number even higher.[141]

The rise of medical malpractice suits has led to escalating malpractice premiums — with an average annual increase of about 15.1 percent between

1982 and 1989.[142] In some specialties the increase has been even higher. As Figure VIII shows, insurance premiums for obstetricians soared during the 1980s and are much higher in areas where lawsuits are more likely. Obstetricians in New York's Nassau and Suffolk counties pay about $100,000 a year and obstetricians in southern Florida pay $200,000.[143] These costs ultimately are borne by patients, either directly or through health insurance premiums.

So far, 15 states have adopted arbitration laws to encourage out-of-court settlements, and 25 states have capped malpractice awards. Of these, 21 place caps on "pain and suffering," Nebraska, South Dakota and Virginia have caps of $1,000,000 on the total award and Indiana has a cap of $750,000.[144] Maine has taken a different direction by establishing "risk management protocols" in the four specialties hardest hit by malpractice claims: anesthesiology, emergency medicine, obstetrics/gynecology and radiology. If physicians in these specialties stay within established parameters in their medical practice, they are immune from litigation.[145]

"The tort system is another bureaucracy, replete with its own perverse incentives."

The tort system is not all bad. Given that third-party payers put enormous pressures on providers to make quality-reducing changes, the tort system may be the single most important protector of patient welfare. By contrast, consider Britain, where the quality-reducing pressures are much greater and the rights of plaintiffs more restricted. When British patients sue hospitals, they are actually suing the government. Unquestionably, there is far more *actual* malpractice in Britain than in the United States.[146]

The primary problem with the tort system is that it is another bureaucracy, replete with its own perverse incentives. Moreover, it is a bureaucracy that feeds off the health care sector with little consideration of the damage done to others. Juries do not even know and are not allowed to consider that huge damage awards set precedents affecting other patients, physicians and hospitals — not just those who are litigating the specific case. And fear of tort liability is a strong incentive for medical providers to withhold and conceal information of vital importance to patients.

To make matters worse, patients, physicians and hospitals have no opportunity to avoid the system by voluntary contract. For example, one sensible way to cut down on negligence litigation is to have the hospital take out a life insurance policy on a patient prior to surgery. The hospital and the patient (or the patient's family) could agree that if the patient dies for any reason, the family will accept the policy's payment as full compensation, unless there was criminal negligence. Litigation costs would be avoided, and life insurance companies would monitor the quality of hospital care. Yet the current tort system does not permit such arrangements.[147]

Making Markets Work in Health Care

American medicine — and particularly the nation's hospitals — show none of the normal signs of a competitive market. In most places, patients cannot find out the cost of even routine procedures before entering a hospital. At the time of discharge, they are presented with lengthy, line-item bills that are virtually impossible to read or understand. Small wonder that there is so much waste in our health care system! The people who make the purchasing decisions cannot discover the price before they buy and, afterward, cannot understand what they were charged.

Hospital Prices. Patients who try to find out about hospital prices before they are admitted face a depressing surprise. A hospital can have as many as 12,000 different line-item prices. For patients doing comparison shopping among the 50 hospitals in the Chicago area, for example, there are as many as 600,000 prices to compare. To make matters worse, different hospitals use different accounting systems. The definition of a service as well as its price may differ from hospital to hospital.

Bureaucracies. The major reason why the market is not competitive is that it is dominated by large, bureaucratic institutions. Because 95 percent of hospital revenues come from third-party payers, prices charged to patients are not market-driven. Instead, they are artificial prices designed to maximize revenue against third-party reimbursement formulas. The federal government has encouraged an institutionalized, bureaucratized market by subsidizing third-party payment. Yet the evidence suggests that the market would be radically different if patients were spending their own funds.

Why Empowering Patients Makes a Difference. In a few areas of the medical marketplace, most of the generalizations made above are no longer true. For example, cosmetic surgery is not covered by private or public health insurance. Yet in every major city, it is a thriving industry. Patients pay with their own money, and they are almost always given a fixed price in advance — covering all medical services and all hospital charges. Patients also have choices about quality (e.g., surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Overall, patients probably have more information about the price and quality of cosmetic surgery than about any other type of surgery.

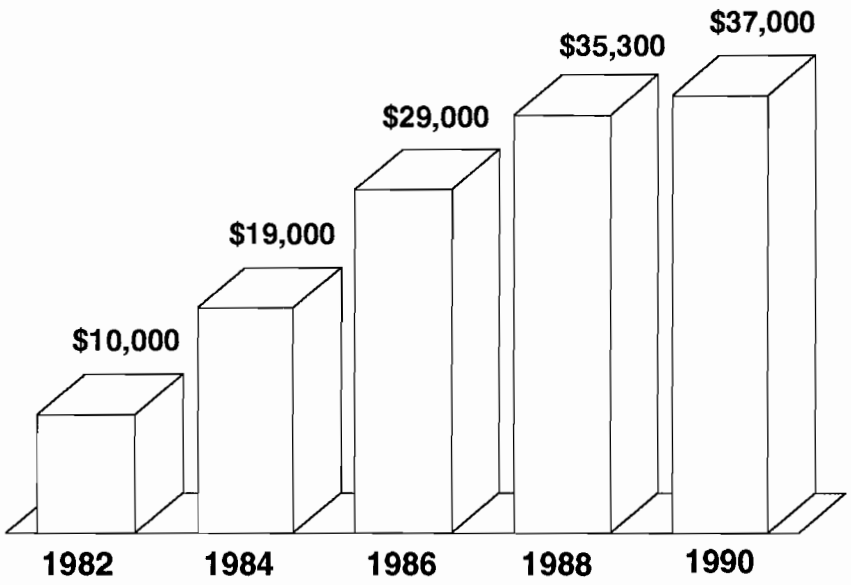
Other Examples. Cosmetic surgery is not an isolated case. Because of the trend toward higher deductibles, parents today can expect to pay a large portion of the bill for well-baby delivery. In response, Humana and other hospital chains are beginning to advertise package prices (from $1,000 to $1,200) in many cities. And, in England, private hospitals frequently offer package prices for routine surgery to patients who pay with their own funds.

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992; and John C. Goodman and Gerald L. Musgrave, *Patient Power : Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

"The rise of medical malpractice suits has led to escalating malpractice premiums."

FIGURE VIII

Average Annual Malpractice Premiums for Obstetricians



Source: *Socioeconomic Characteristics of Medical Practice* (Chicago: American Medical Association, 1990-91), Table 55, p. 147.

Most proposals to solve this problem would place arbitrary limits on the rights of plaintiffs in malpractice suits. Not all of these proposals are bad. But they share the common flaw of attempting to solve problems by bureaucratic fiat rather than by voluntary, mutually beneficial exchanges. Why not allow patients to make contractual agreements in their own interests? Patients should have the same rights as buyers in other markets, including the right to waive certain tort claims, in return for cost-of-services reductions or other monetary compensation.

Mediocre Idea: Managed Care. As noted above, many misguided proposals for health insurance reform would impose managed care on people through government policy. A better way is to allow managed care to compete with its alternatives on a level playing field. Let the market determine which techniques survive and which do not.

In the context of competitive markets, many of the techniques developed by the managed care bureaucracy might prove useful. Clearinghouses for information on prices and quality could be valuable to patients. Computerized protocols could be valuable for physicians if they were voluntary. With greater information at their disposal, patients and physicians could manage their own care. What managed care (or "coordinated care") means to many

people, however, is not an aid to competitive markets but a substitute for them. All too often the managed care bureaucracy envisions a world in which the managers have one set of goals, while 250 million patients and physicians have different goals. This private sector socialism would have many of the same defects as public sector socialism.

With respect to small-dollar items — from blood tests to CAT scans — it is doubtful that managed care can reduce costs at all, let alone eliminate waste. The cost of managing these expenditures is probably higher than any benefit to be derived. And imposing arbitrary rules introduces the risk of mistakes that would lead to expensive tort liability lawsuits. With respect to high-dollar items, managed care has had some successes. But the most impressive gains occur when managers use markets rather than trying to replace them.[148]

Worse Idea: Price Controls. The idea that government should fix the price for third-party reimbursement is increasingly popular. For Medicare patients, the federal government already fixes prices for hospital services [149] and is in the process of doing so for physicians' services.[150] Two things can go wrong when government arbitrarily fixes prices. If it sets the price too high, it encourages overprovision. If it sets the price too low, it encourages underprovision. The tendency is to set the price too low, in order to control spending. As a result, price controls tend to become a vehicle for health care rationing. Take Medicare, for example. Intentionally or not, Medicare's payment formulas are affecting patients:

"Price controls tend to become a vehicle for health care rationing."

- Although hearing loss is the most prevalent chronic disability among the elderly and affects one-third of all Medicare patients, Medicare's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.[151]

- When Medicare reduced the reimbursement rate (in real terms) for kidney dialysis in the 1980s, many physicians reduced the treatment time — a practice that reduced patients' chances of survival.[152]

- A survey of 21 medical conditions for which an implanted medical device is indicated found that for 18 of them the government's payment was well below hospital cost, and in more than half the cases Medicare patients did not receive the device.[153]

Even when Medicare's reimbursement equals the average cost of treatment, price fixing discriminates against above-average-cost patients. These tend to be the sickest patients and more often than not they are low-income and nonwhite. For example, blacks and Hispanics have more severe

illnesses, longer hospital stays and higher hospital costs than white patients, on the average.[154]

Price controls are also used in the Medicaid program, where it is not uncommon for government to pay as little as 50 cents on the dollar for services for low-income patients. One consequence is that pregnant women on Medicaid are denied access to most OB/GYN physicians and often turn to hospital emergency rooms as the only alternative for prenatal care.

Very Worst Idea: Global Budgets. In most other developed countries, hospitals or area health authorities are given a fixed budget and required to deliver health care within that budget. Although the idea of living within a budget sounds reasonable on the surface, in practice "global budgeting" is a euphemism for health care rationing. By limiting what hospitals can spend, governments force them to ration health care.

"When health care is rationed, the principal victims are the poor, the elderly, racial minorities and rural residents."

There is considerable evidence that when health care is rationed, the principal victims are the poor, the elderly, racial minorities and rural residents. [See the sidebar on Canada's global budgets.] Moreover, there is no evidence that global budgets lead to greater efficiency. To the contrary, they almost certainly encourage inefficiency. Consider the experience of three English-speaking countries with cultures similar to our own:

- Currently the number of people waiting for surgery totals more than one million in Britain,[155] 50,000 in New Zealand [156] and 260,000 in Canada.[157]
- Although those waiting represent a small percent of the total population (1 to 2 percent), they probably represent a large portion of those who need access to modern medical technology.[158]
- Yet in spite of the lengthy waiting lists, at any one time about one-fifth of all hospital beds are empty in all three countries and another one-fourth are being used for expensive nursing home care of nonacute elderly patients.[159]

Problem: Paying for Reform

Even good ideas cost money. How should health care reform be financed?

Good Idea: Use General Revenues. If there is any reason for government to subsidize health care or health insurance for low- and moderate-income families, presumably it is to serve the "public good." Accordingly, the

appropriate way to fund such activities is through general revenues collected from the entire public — with higher burdens for those with greater ability to pay.

Bad Idea: Tax Sick People. A number of proposals would pay for health care reform by taxing hospital beds or hospital revenues. New Jersey currently imposes a 19 percent tax on all hospital bills (except those of Medicare patients) and uses the money to subsidize indigent hospital care and hospital discounts for Blue Cross and Blue Shield patients. Connecticut adds to each hospital bill what amounts to a 30 percent tax. Minnesota's new reform plan is to be financed by a 1 percent tax on premiums paid to HMOs, a 2 percent tax on the revenues of hospitals, physicians and wholesale drug distributors, and a 5 cents-per-pack cigarette tax.[160] To discourage Minnesotans from seeking untaxed hospital care outside the state, Minnesota plans to impose its tax on out-of-state hospitals that care for 20 or more Minnesotans per year — "not just in bordering states, any state, even Canada."[161] As noted earlier, New Jersey's practice of taxing the hospital bills of employees of self-insured companies has been struck down by the courts[162] and it seems likely that Minnesota's will be as well.

"Taxing the sick takes funds from people at a time in their lives when they can least afford it."

These ideas are partly a continuation of a long-established hospital practice of financing charity care by overcharging paying patients. Unfortunately, taxing the sick takes funds from people at a time in their lives when they can least afford it.

Bad Idea: Tax Health Insurance. Another common proposal is to fund health care reform by taxing health insurance. For example, most health insurance risk pools are funded by a tax on health insurance premiums. And many health insurance reform proposals are designed to lower premiums for high-risk (or sick) people by raising them for low-risk (or healthy) people. If it is socially desirable for people to have health insurance, then any policy that artificially raises premiums is inconsistent with achieving that goal. Charging healthy people higher premiums simply discourages them from being insured.

Worst Idea: Tax Rich People. A popular way of funding any government program is to raise taxes on high-income earners. Unfortunately, these taxes usually fall on investment income, harming workers and the economy far more than the people who are taxed. In general:[163]

- People who earn more than $250,000 per year derive 65 percent of their income from investments.
- People who earn more than $1 million a year derive 75 percent of their income from investments.

What's Wrong with Canada's Global Budgets?

Canada attempts to control health care spending by restricting sophisticated services to hospitals and severely limiting hospital budgets. In most provinces, outpatient surgery is either prohibited or discouraged. In Ontario, CAT scanners and MRI scanners are restricted to hospitals by law. The results are inefficient and unfair.

Lack of Access to Technology. Unlike an American, a Canadian concerned about headaches cannot simply walk in and receive an MRI scan. Even for those patients doctors deem to be in great need, the waiting list for a brain scan in Ontario is now one year and four months. Nor can a Canadian with high cholesterol easily get a cholesterol test. In most provinces the screening standards are much stricter than American doctors consider appropriate. One reason why gaining access to technology in Canada is difficult is that the technology isn't there.

Rationing by Waiting. There are 260,000 Canadians waiting for medical care. Patients can wait as long as five months for a Pap smear, eight months for a mammogram and more than a year for heart surgery. The Canadian press is full of stories of patients dying because they did not get surgery promptly. And, as in other countries with global budgets, in Canada rationing decisions are haphazard. There is no national waiting list and no mechanism to ensure that the patients in greatest need receive care first.

Unequal Access to Care. Access to care is anything but equal. For example, among the 30 health regions of British Columbia, access to physicians varies by a factor of six to one. Access to specialists varies by a factor of 12 to 1, and access to some specialties varies by a factor of 35 to 1.

Discrimination against the Poor. As in the United States, low-income families have shorter life expectancies and higher infant mortality rates.

Discrimination against Racial Minorities. In both the United States and Canada, Indians have shorter life expectancies than the rest of the population. However, life expectancy is five years longer for an American Indian male and six years longer for a female. Indian infant mortality is almost twice as high in Canada as in the United States.

Discrimination against the Elderly. Health care rationing in every country tends to favor the young over the old. Canada is no exception. Per capita, the United States performs twice as many coronary artery bypass operations on elderly patients as Canada does. Among 75-year-olds, the difference between the two countries is four to one.

Sources: John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991; and Michael Walker, Fraser Institute, author communications.

Taxes on high-income earners, therefore, are almost always taxes on investment income. As a result, wealthier people save less and invest less. Thus, higher taxes on investment income invariably reduce investment, lower wages and eliminate jobs. Usually, such taxes also cause a net loss of revenue rather than a gain. Under the current tax structure for the nation as a whole:[164]

- For every dollar of aftertax income to investors, workers receive $12 in aftertax wages and government receives another $12 in tax revenue.
- Thus every extra dollar taken from investors ultimately means $12 less in revenue for government.

Conclusion

The message coming to our shores from every corner of the globe is: socialism, collectivism and bureaucracies do not work. The only thing that works is individuals pursuing their own interests in competitive markets. That message applies to health care as well as to other activities. If state legislators wish to enact humane and efficient health care reform, they must empower people to use their intelligence, creativity and innovative ability to solve problems in freely competitive markets.

"The only thing that works is individuals pursuing their own interests in competitive markets."

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 or any state legislature.

Footnotes

[1] Source: Health Care Financing Administration. Statistics are for personal health expenditures.

[2] The Rand Corporation, in a study conducted from 1974 to 1982, found that people who had access to free care spent about 50 percent more than those who had to pay 95 percent of the bills out-of-pocket up to a maximum of $1,000. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today. See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand Corporation, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review,* June 1987. For the most recent survey, see Michael A. Morrisey, *Price Sensitivity in Health Care: Implications for Health Care Policy* (Washington, DC: The NFIB Foundation, 1992). For a survey of economic studies of the demand for medical care, see Paul Feldstein, *Healthcare Economics* (New York: Wiley, 1988).

[3] This estimate assumes a $33 billion decrease in administrative costs and a $147 billion decrease in direct expenses. Total health care costs for 1991 were estimated at $707 billion. See the analysis in John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

[4] The Rand study found no significant differences in the health status of people who had high and low deductibles. The one exception was vision care, which is not surprising — since eyeglasses are often viewed as a marginal health care expenditure. See Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, Vol. 305, No. 25, December 17, 1981, pp. 1501-7; and Robert Brook et al., "Does Free Care Improve Adults' Health?" *New England Journal of Medicine*, Vol. 309, No. 23, December 8, 1983, pp. 1426-34.

[5] Source: Golden Rule Insurance Company. Figures are for two adults and two children.

[6] For deductibles less than $2,500, policyholders face a 20 percent copayment up to, $1,000. Thus, the forgone coverage is 80 percent x ($1,000 - $250) = $600. The savings from a higher deductible are even greater considering that more than one family member can incur expenses. Under the low-deductible policy, the deductible is $250 per person, with a $500 maximum for the entire family. Under the high-deductible policy, the deductible indicated is for the entire family.

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

[8] See Goodman and Musgrave, "Controlling Health Care Costs with Medical Savings Accounts."

[9] Acting on a proposal made by the National Center for Policy Analysis, the state of Colorado has established medical IRAs — tax-favored savings for postretirement health care. Yet because these accounts are subject to the federal income tax — there is no federal income tax deduction for the deposit, and interest earnings are subject to tax — the incentives to take advantage of them are weak.

[10] Estimate of the Health Care Financing Administration, Office of the Actuary, Fall 1991.

[11] The primary tax subsidy is the exclusion of employer-provided health insurance from employees' taxable income.

[12] Calculated from data in the National Health Accounts, Health Care Financing Administration.

[13] Source: NCPA/Fiscal Associates health care model. Data derived from the Health Care Financing Administration, Office of the Actuary, National Health Expenditures estimates, augmented with the estimates of the values of tax subsidies.

[14] Source: Health Care Financing Administration. See Gary Robbins, "Insurance as the Source of Medical Inflation," paper presented to the Cato Institute conference, "The Regulation of Medical Care," Washington, DC, April 30, 1992.

[15] Source: NCPA/Fiscal Associates health care model.

[16] See John C. Goodman, "How the Federal Government Is Causing Our Nation's Health Care Crisis," National Center for Policy Analysis, NCPA Policy Backgrounder No. 119, June 22, 1992.

[17] See the discussion in Lucy Johns and Gerald S. Adler, "Evaluation of Recent Changes in Medicaid," *Health Affairs,* Spring 1989, p. 179.

[18] Federal regulations relating to nursing homes are in National Fire Protection Agency (NFPA) *101 Life Safety Codes*, 1985 edition.

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

[20] Unemployed people and employees of firms that do not provide health insurance receive no tax subsidy for the health insurance they purchase. Self-employed individuals are allowed to deduct 25 percent of their health insurance premiums, but this provision has an uncertain future. The deduction must be periodically renewed by Congress and is not a permanent feature of the tax code.

[21] See Employee Benefit Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," *EBRI Issue Brief*, No. 66, May 1987, Table 2, p. 3.

[22] See Task Force Report, "An Agenda for Solving America's Health Care Crisis," National Center for Policy Analysis, NCPA Policy Report No. 151, May 1990.

[23] Kenneth H. Bacon, "Business and Labor Reach a Consensus on Need to Reduce Health Care Costs," *Wall Street Journal,* November 1, 1989.

[24] Employee Benefit Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," p. 7.

[25] Aldona Robbins and Gary Robbins, "Taxing the Savings of Elderly Americans," National Center for Policy Analysis, NCPA Policy Report No. 141, September 1989.

[26] Jonathan C. Dopkeen, "Postretirement Health Benefits," in *The Sourcebook on Retirement Health Care Benefits*, Robert D. Paul, ed. (Greenvale, NY: Panel Publishers, 1988), p. 566.

[27] See John C. Goodman and Gerald L. Musgrave, "Health Care After Retirement: Who Will Pay the Cost?" National Center for Policy Analysis, NCPA Policy Report No. 139, July 1989.

[28] Mark J. Warshawsky, "Retiree Health Benefits: Promises Uncertain," *The American Enterprise*, July/August 1991, Figure 2, p. 63.

[29] Source: Health Care Financing Administration. Dollar amounts are for 1991.

[30] See Goodman and Musgrave, "Health Care After Retirement: Who Will Pay the Cost?"

[31] These companies are exempt from state regulations under the provisions of the Employee Retirement Income Security Act (ERISA), 1974.

[32] Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits," *Inquiry,* Vol. 26, No. 4, Winter 1989, pp. 419-31.

[33] Milt Freudenheim, "States Seek Aid for the Uninsured," *New York Times*, June 23, 1992.

[34] Joseph F. Sullivan, "New Jersey Surcharge for Poor Patients Is Voided," *New York Times*, May 28, 1992.

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

[36] If employees pay any part of the premium, the price tends to be the same for all — regardless of expected health care costs.

[37] Polls show that about 30 percent of employees experience "job lock" — a condition under which they fear switching jobs because of a loss of health insurance benefits. Eric Echolm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.

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

[39] See the discussion in Edmund F. Haislmaier, "Health Care," in *Making Government Work: A Conservative Agenda for the States,* Tex Lezar, ed. (San Antonio: Texas Public Policy Foundation, 1992), pp. 201-206.

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

[41] See the ALEC model legislation.

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

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

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

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

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

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

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

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

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

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

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

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

[50] In New York, Guardian Insurance (a commercial insurer) charges a monthly premium of $149 to single people under age 30 and $349 to single people age 60 to 64. By contrast, Blue Cross — which must community rate — charges $184, regardless of age. See Peter Passell, "What Hidden Cost In Spreading the Health Risk?" *New York Times,* July 12, 1992. In states where insurers can rate based on sex, the premium difference for males of different ages is greater than for females.

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

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

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

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

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

[56] In the absence of a competitive market, people living in countries with national health insurance perversely may find it in their rational self-interest to vote for a policy of increased primary care services funded by a reduction in acute care services. See the analysis in John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

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

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

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

[60] The California proposal has been introduced by the state's insurance commissioner, John Garamendi. See Lou Cannon, "California Official Offers Health Plan," *Washington Post*, February 13, 1992; and "Good Health — and Good Politics," *New York Times*, June 27, 1992. On the connection of the California plan to Alain Enthoven, see Ken McDonnel, Michael Anzick and William Custer, "State Initiatives in Health Care Reform," Employee Benefit Research Institute, *EBRI Issue Brief*, No. 127, June/July 1992.

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

[62] "The President's Comprehensive Health Reform Program," February 6, 1992. During an initial transition period, premium "bands" would allow some variation in premiums for individuals of the same age and sex. Ultimately, however, through a reinsurance mechanism, "insurers would be able to provide coverage at a near uniform premium for the sick and the healthy." (p. 23)

[63] "In cases where a hospital emergency room is an individual's first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So, for example, a homeless person entering the hospital and having no preference for any carrier would be assigned to an insurer by rotation and the credit would automatically flow to the insurer." "The President's Comprehensive Health Reform Program," p. 22. Technically, a "credit-eligible" person is one whose annual income does not exceed $50,000 for an individual or $80,000 for a family. However, since the hospital will almost certainly not know the emergency-room patient's income until several days after treatment, and since there is no waiting period, the proposal apparently envisions a mechanism that will insure any uninsured patient entering the hospital.

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

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

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

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

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

[69] See the summary in Enthoven, *Health Plan,* pp. 114-15.

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

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

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

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

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

Maryland Health Plan Is a Model for the Nation," Heritage Foundation, Heritage Lectures No. 392, May 27, 1992.

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

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

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

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

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

[80] See the discussion in Goodman and Musgrave, *Patient Power: Solving America's Health Care Crisis.*

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

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

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

[84] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey," *EBRI Issue Brief*, No. 123, February 1992.

[85] Katherine Swartz and Timothy D. McBride, "Spells Without Health Insurance: Distribution and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry*, Vol. 27, Fall 1990, pp. 281-88.

[86] "Bare bones" policies are policies that are exempted from some or all mandated health insurance benefits.

[87] John C. Goodman, "Regulation of Health Insurance by State Governments," in Tex Lazar, ed., *Making Government Work: A Conservative Agenda for the States* (San Antonio: Texas Public Policy Foundation, 1992), p. 237. See also "Bare Bones Health Insurance: An Emerging Consensus in the States," *Health Benefits Letter,* Vol. 1, No. 8, May 23, 1991; and "Small Group Market Reform Laws Enacted in 16 States," *Health Benefits Letter,* Vol. 1, No. 13, August 8, 1991.

[88] Senator Edward Kennedy (D-MA), for example, has proposed such legislation. For an analysis, see John C. Goodman, Aldona Robbins and Gary Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1989.

[89] This type of proposal was first unveiled at the federal level in 1991 by Senators Mitchell (D-ME), Kennedy (D-MA), Rockefeller (D-WV) and Riegle (D-MI). Under the bill, employers would have a choice: pay a federal tax, tentatively set between 7 and 9 percent of payroll, or provide health insurance for their employees. If employers opted to pay the tax, the government would assume responsibility for providing health insurance.

[90] This has been a consistent feature of all three Heritage reform plans. For example, the first element of the Heritage Foundation's original plan states, "Every resident of the U.S. must, by law, be enrolled in an adequate health care plan to cover major health care costs." Interestingly, the only penalty recommended for failure to comply is a fine. See Butler and Haislmaier, *A National Health System for America*, p. 51. See also Mark Pauly et al., "A Plan for 'Responsible National Health Affairs'," *Health Affairs*, Spring 1991, pp. 5-25.

[91] Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs*, Fall 1991, pp. 43-44. Tax relief is available only for those 65 years of age or older.

[92] Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand* (Wellington: New Zealand Business Roundtable, 1991).

[93] Goodman and Musgrave, "Twenty Myths About National Health Insurance."

[94] Though unemployment in Massachusetts was only 2.9 percent in April 1988, it had risen to 8.6 percent in January 1991 —

the highest of any industrial state at the time. Richard Kronick, "Can Massachusetts Pay for Health Care for All?" *Health Affairs*, Spring 1991, p. 27.

[95] See "Universal Health Care Act of 1988: Chapter 23," Coopers & Lybrand, Boston, 1988. In an effort to address the rising costs and access problems, the Massachusetts legislature recently passed "Chapter 495," which is designed to radically restructure how hospitals are paid and implement small group reform. For an analysis see "An Act Improving Health Care Access and Financing: Chapter 495," Coopers & Lybrand, Boston, 1992.

[96] Though Kronick supports pay-or-play legislation, he concedes that it would force some businesses to close down or decrease wages, while many other employers would cancel their coverage and pay the tax. "Can Massachusetts Pay for Health Care for All?" p. 36-41.

[97] Attiat R. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?* (Boston: Pioneer Institute for Public Policy Research, 1988).

[98] It is the only state that has such an exemption.

[99] As of June 1992, 17,233 individuals of the approximately 50,000 people eligible for SHIP were covered. See McDonnell et al., "State Initiatives in Health Care Reform," p. 23.

[100] Ibid. The estimate was made by a study sponsored by Blue Shield of Hawaii. However, a different study by Martin E. Segal Company places the number at 46,000.

[101] See the discussion in Emily Friedman, "Health Insurance in Hawaii: Paradise Lost or Found?" *Business and Health*, June 1990, pp. 52-59.

[102] Rita Ricardo-Campbell, "Business Health Care Costs and Competition," Working Papers in Economics, No. E-91-6, Hoover Institution, Stanford University, February 1991, p. 34.

[103] For a state-by-state survey of risk pools, see *Comprehensive Health Insurance for High-Risk Individuals*, 6th ed. (Minneapolis: Communicating for Agriculture, 1992).

[104] Ibid.

[105] Health insurance risk pools are created and partially funded by state governments in order to make health insurance available to high-risk individuals, who might otherwise not be able to obtain health insurance. Though premiums are usually 50 percent higher than comparable policies sold in the market, most risk pools incur losses. See *Comprehensive Health Insurance for High-Risk Individuals.*

[106] In 1990, pools paid out $77.6 million more than they took in. McDonnell et. al., "State Initiatives in Health Care Reform," p. 29.

[107] Ibid.

[108] *Comprehensive Health Insurance for High-Risk Individuals.*

[109] "1,081 State Mandated Benefits Identified," *Health Benefits Letter,* Vol. 2, No. 2, July 31, 1992.

[110] Gabel and Jensen, "The Price of State-Mandated Benefits."

[111] 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.

[112] Greg Scandlen, "State Mandated Coverage: Mandate Evaluation Laws," Blue Cross/Blue Shield, Office of Government Relations, Washington, DC, November 1989.

[113] See John C. Goodman, "Health Insurance: States Can Help," *Wall Street Journal,* December 17, 1991.

[114] "Mandated Benefits: Mixed Signals From the States," *Health Benefits Letter*, Vol. 1, No. 3, March 13, 1991.

[115] Employee Benefit Research Institute, *Employee Benefit Notes*, Vol. 8, No. 9, September 1987, p. 7.

[116] These categories are not mutually exclusive; all three characteristics could be used to describe the same family.

[117] U.S. Office of Technology Assessment, *Health Care in Rural America* (Washington, DC: September 1990).

[118] See John C. Goodman and Gerald L. Musgrave, "National Health Insurance and Rural Health Care," National Center for Policy Analysis, NCPA Policy Report No. 107, October 1991.

[119] Office of Technology Assessment, "Nurse Practitioners, Physicians' Assistants and Certified Nurse-Midwives: A Policy Analysis," Health Technology Case Study No. 37, December 1986. See also John C. Goodman, *Regulation of Medical Care:*

Is the Price Too High? (Washington, DC: Cato Institute, 1980).

[120] See Goodman and Musgrave, "National Health Insurance and Rural Health Care," and Goodman and Musgrave, *Patient Power: Solving America's Health Care Crisis.*

[121] Medicaid grants two basic types of waivers: "demonstration projects" and program waivers. Demonstration projects such as the Arizona Health Care Cost Containment System (AHCCCS), which began in 1982, must submit comprehensive programs to the Secretary of Health and Human Services for approval. The state of Oregon recently had its Medicaid demonstration project rejected by HHS under this system. Program waivers usually take a less innovative approach to cost containment. For example, it might permit a state to disregard Medicaid's fee-for-service provision and enroll Medicaid recipients in Health Maintenance Organizations. See The House Wednesday Group, Congress of the United States, "Primer on Medicaid Waivers, ERISA and State Health Initiatives," Washington, DC, July 1992. See also the discussion in Haislmaier, "Health Care."

[122] *Statistical Abstract of the United States 1990,* 110th ed., U.S. Department of Commerce, Bureau of the Census, p. 98.

[123] John Holahan and Sheila Zedlewski, "Expanding Medicaid to Cover Uninsured Americans," *Health Affairs,* Spring 1991, p. 49.

[124] Andrew J. Cowin, "How Washington Boosts State and Local Budget Deficits," Heritage Foundation, Backgrounder No. 908, July 31, 1992.

[125] Under the federal medical assistance percentage (FMAP), a state can receive from 50 to 83 percent of its Medicaid budget from the federal government. The assistance range is based on the state's per capita income.

[126] McDonnell et al., "State Initiatives in Health Care Reform."

[127] Ibid., Table 5, p. 12.

[128] Robert Pear, "Low Medicaid Fees Seen as Depriving the Poor of Care," *New York Times*, April 2, 1991. See also Don Terry, "As Medicaid Fees Push Doctors Out, Chicago Patients Find Fewer Choices," *New York Times,* April 12, 1991; and Elizabeth Kolbert, "Medicaid in New York: Costs Surge but Care for Poor Still Lags," *New York Times*, April 15, 1991.

[129] Robert Pear, "Suits Force U.S. and States to Pay More for Medicaid," *New York Times*, October 29, 1991.

[130] Ibid.

[131] In 1989 and again in 1991, the state legislature modified and amended the Oregon Health Plan to extend Medicaid coverage to an additional 120,000 low-income people and to require employers to provide employer-based health insurance coverage for another 300,000 employees. If enacted, by 1994 employers will have to provide health insurance or pay a payroll tax. See McDonnell et al., "State Initiatives in Health Care Reform."

[132] See Timothy Egan, "Oregon Shakes Up Pioneering Health Plan for the Poor," *New York Times,* February 22, 1991.

[133] For a comparison of the highest and lowest ranked Medicaid conditions see Egan, "Oregon Shakes Up Pioneering Health Plan for the Poor."

[134] "Oregon Rationing Plan to Apply to Private Sector Benefits," *Health Benefits Letter,* Vol. 1, No. 2, February 28, 1991.

[135] "Oregon's Bid to Boost Coverage Gets Federal Red Light," *Congressional Quarterly*, August 8, 1992, p. 2362.

[136] See Joseph A. Califano, *America's Health Care Revolution: Who Lives, Who Dies, Who Pays?* (New York: Random House, 1986).

[137] Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?"

[138] Haislmaier, "Health Care," pp. 210-212.

[139] The Wyatt Co., "Cost Analysis of State Legislative Mandates on Six Managed Care Practices," produced by the Health Insurance Association of America, July 1991, and reported in *Medical Benefits,* Vol. 8, No. 17, September 15, 1991, pp. 9-10. See also, "Utilization Review Laws: 'Hassle Factor' Inspires Provider Push for Restrictions," *Health Benefits Letter,* Vol. 1, No. 14, August 22, 1991.

[140] Milt Freudenheim, "Dealing in Myths on Malpractice," *New York Times,* October 13, 1992.

[141] See Peter W. Huber, *Liability: The Legal Revolution and Its Consequences* (New York: Basic Books, 1988); and J. E. Moser and R. A. Musacchio, "The Costs of Medical Professional Liability in the 1980's," *Medical Practice and Management,* Summer 1991.

[142] *Socioeconomic Characteristics of Medical Practice* (Chicago: American Medical Association, 1990-91).

[143] Milt Freudenheim, "Costs of Medical Malpractice Drop After an 11-Year Climb," *New York Times,* June 11, 1989.

[144] McDonnell et al., "State Initiatives in Health Care Reform," pp. 33-34.

[145] Detractors call such protocals "cook book" medicine, and argue that they encourage physicians to consider the government first, the employer second and the patient last.

[146] See John C. Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980), pp. 121-22.

[147] More precisely, the current system ignores contractual waivers of tort liability claims. What is needed is a legal change requiring the courts to honor certain types of contracts under which tort claims are waived in return for compensation.

[148] For example, a national market is developing for expensive heart surgery in which "centers of excellence" bid for the opportunity to perform these operations for corporate, insurance and government buyers.

[149] Medicare pays hospitals a predetermined reimbursement fee for 492 diagnosis-related groups. Medicare's DRG system for reimbursing hospitals is a price-fixing scheme in which the government is attempting to create an artificial market. DRG reimbursement prices do much more than limit the amount that government will pay. Since Medicare patients cannot add their own funds to the DRG rate and hospitals cannot give rebates to patients, Medicare literally fixes the prices of services rendered, independent of supply and demand.

[150] The Health Care Financing Administration (HCFA) began on January 1, 1992, to phase in the Resource Based Relative Value Scale (RBRVS), a cost control and payment program that reimburses physicians who care for Medicare patients.

[151] Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine*, Vol. 321, No. 21, November 16, 1989, pp. 1378-83.

[152] Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 909-10. See also Phillip J. Held et al., "Mortality and Duration of Hemodialysis Treatment," *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 871-75.

[153] Kane and Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," p. 1379.

[154] Eric Muñoz et al., "Race, DRGs, and the Consumption of Hospital Resources," *Health Affairs,* Spring 1989, p.187.

[155] Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," p. 43.

[156] See *Choices for Health Care: Report of the Health Benefits Review* (Wellington, New Zealand: Health Benefits Review Committee, 1986), pp. 78-79; and John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance."

[157] Estimate of the Fraser Institute (Vancouver) based on sampling in five Canadian provinces. Michael A. Walker et al., "Waiting Your Turn: Hospital Waiting Lists in Canada," Fraser Institute, Critical Issues Bulletin, February 1992.

[158] It is estimated that in the United States about 4 percent of the population accounts for about 50 percent of total health care costs. These are the patients who require access to expensive technology.

[159] For New Zealand, estimate of the New Zealand Department of Health. OECD statistics show an occupancy rate of 74.8 percent for New Zealand in 1983 and 83.3 percent for Canada. See Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris: OECD, 1987), Table 29, p. 67. The most recent OECD statistics are expected to show an occupancy rate of 80.3 percent for acute care hospitals and 82.7 percent for all hospitals in Canada for 1987. See George J. Schieber et al., "Health Care Systems in Twenty-four Countries," Exhibits 4 and 5, pp. 27, 29. In England, hospital occupancy rates are 74 percent for acute beds and 82 percent for all beds. See Office of Health Economics, *Compendium of Health Statistics,* 7th ed. (London: OHE, 1989), Section 3, p. 39.

[160] Keith J. Halleland and S. Olivia Mastry, "HealthRight's Mandate for Change," *Minnesota Medicine,* Vol. 75, June 1992.

[161] *Wall Street Journal,* September 2, 1992.

[162] See Joseph F. Sullivan, "Judge Stays Ruling on Hospital Billing in New Jersey," *New York Times*, June 5, 1992.

[163] Aldona Robbins and Gary Robbins, "Capital, Taxes and Growth," National Center for Policy Analysis, NCPA Policy Report No. 169, January 1992.

[164] Ibid.

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