HERITAGE TALKING POINTS

A Checklist on Vital National Issues

A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS

PART II: THE HERITAGE CONSUMER CHOICE HEALTH PLAN

By Stuart M. Butler, Ph.D.

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INTRODUCTION

Part I of this *Talking Points* series on health care explained that proposals to reform America's health care system generally are based on one of three approaches. Each approach uses a different mechanism to allocate health care resources and to determine what services a family receives. These three methods are:

1) **The Single-Payer (or "Canadian") Approach.** The government becomes the monopoly provider of health care financing. It fixes a budget for health care and allocates money to hospitals, and it sets physician fees.

2) **The "Play or Pay" Approach.** The government gives employers a choice: either provide at least a specified health insurance plan to employees and their families, or pay a payroll tax to finance a public program for their health benefits, as well as for those Americans not currently insured. The government runs the public program and employers are responsible for financing and managing private insurance.

3) **The Consumer Choice Approach.** Americans are allowed to choose the health care plan they want. Unlike today, where government help to obtain a plan effectively is restricted to employer-sponsored plans, families would receive the same amount of government help wherever they obtained coverage. Further, there would be more help for the sick and the low-paid, less for the healthy and the high-paid. No national budget for health care would be set by the government, and efficient allocation and cost control would be determined by consumer choice and competition among providers.

Many of the key features of a consumer-based system already exist in the Federal Employee Health Benefits Program (FEHBP). This covers congressmen and their staff, agency heads and employees, and judicial branch employees—in all over nine million workers, their dependents, and retirees. Several proposals are versions of a consumer-based system. The Bush Administration's recent health proposal would establish such a system for today's uninsured.

A comprehensive proposal has been introduced in the Senate (S. 2095) by Steve Symms and Larry Craig, both Idaho Republicans, and elements of a consumer-choice model are included in a bill (S. 1936) introduced by Senator John Chafee, the Rhode Island Republican.

In addition, The Heritage Consumer Choice Health Plan has been developed by The Heritage Foundation.[1]

This *Talking Points* examines the Heritage plan in detail. It reviews the plan's features and implications. It also contains the findings of an analysis of the Heritage plan by Lewin/ICF, a leading Washington-based econometric firm specializing in health economics. The Lewin/ICF study was commissioned by Heritage. Lewin/ICF conducts similar analyses for the Administration, Congress, and the private sector.

HOW THE HERITAGE CONSUMER CHOICE HEALTH PLAN WORKS

The Heritage plan would create a health care system in America in which all families would have access to an affordable health plan and would choose the plan they wanted. Today a family normally must change its plan, or even lose coverage, when the head of household changes jobs or faces unemployment. Under the Heritage proposal, the family would keep the same insurance without interruption when changing jobs—much as families keep the same life insurance, car insurance, homeowner's insurance or mortgage. In addition, the tax code would be changed to give more help to lower-paid or sick families to afford health care. This change would not increase the federal deficit.

Reduced to its central elements, the Heritage plan involves two principal steps:

Step #1: Convert the tax exclusion for company-sponsored plans into a tax credit for plans from any source.

When a family is covered by an employer-sponsored health plan as part of the breadwinner's total compensation, the value of the benefits is not included in the family's taxable income. This is like a tax deduction for the family.[2] This is known as a "tax exclusion." For the vast majority of Americans, this is the only

1 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Using Tax Credits to Create an Affordable Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of the American Medical Association*, Volume 265, May 15, 1991.

2 It is actually more generous than a tax deduction for lower-paid families and many middle-income families, because Social Security taxes are not applied. Tax deductions by contrast are free of income tax, but not of Social Security taxes.

way they can obtain a tax break for health care costs (for the implications of this, see *Talking Points, Part I: The Debate Over Reform*, February 12, 1992).[3]

Under the Heritage plan, the current exclusion for company-provided plans, as well as other minor health tax deductions, would be replaced with a new tax credit available to all non-elderly and non-Medicaid families for the purchase of health insurance and out-of-pocket medical costs. The cost to the Treasury for the credit would exactly equal the cost of current tax breaks. In Washington jargon, this makes the plan "budget neutral."

Q: What does that mean for employees who have a company plan? Would they pay higher taxes?

A: **Generally no.** It just means families would gain tax relief in a different way. If they had a company-sponsored plan, the cash value of that plan now would appear as a taxable item on their end-of-year W-2 tax form from the employer. But the family then would be able to claim a credit for the cost of employer-sponsored plan and for out-of-pocket costs, such as deductibles. Further, if the family chose a plan from a source other than their employer, the employer would be required to "cash out" their current benefits by adding the value of those benefits to the worker's paycheck. As described below, the Lewin/ICF analysis of the proposal indicates that most families would pay slightly lower total taxes after this switch. And while some families would pay higher taxes, it would be because they had found ways to cut their medical insurance costs and thus gained more (taxable) income for other purposes.

Q: What about families without a company plan?

A: **They would receive a credit for buying insurance and out-of-pocket medical care.** Today these families normally receive no tax help or any other assistance, unless they go on welfare.

Q: What about the working poor, who pay little or no tax?

A: **The new credit would be refundable.** This means that if the family's credit exceeded its tax liability, it would receive the difference from the government, in the form of a voucher that could be used only for health care.

3 Three smaller tax breaks are available for some Americans. The self-employed can deduct 25 percent of the cost of insurance. Americans with high out-of-pocket medical costs can deduct the amount in excess of 7.5 percent of their adjusted gross income if they itemize their tax return. And low-income working Americans can obtain a credit for certain insurance to cover their children, through the earned income tax credit (EITC).

Step #2: Require all households to purchase at least a basic package of insurance, unless they are covered by Medicaid, Medicare, or other government health programs.

All heads of households would be required by law to obtain at least a basic health plan specified by Congress. The refundable credit system partially would offset the cost of such a plan for most Americans, as the exclusion does today for those with company-sponsored plans.

In addition to these core steps, the Heritage plan would institute reforms to smooth the transition to the consumer-based national system and to enable the market for health insurance and medical care to operate more effectively. Among these, the plan would:

- ✘ **Reform the insurance market:** The private insurance market would be reformed to make a standard basic package available to all at an acceptable price (see below).

- ✘ **End state insurance mandates:** Most states mandate that insurance sold within their borders must cover certain services. These mandates would in effect be preempted, to allow the basic plan to be marketed throughout the United States and to permit new types of group sponsors to sell plans. In addition, plans could not be made subject to state restrictions on managed care. These state mandates could be preempted by federal law, as they are for the Federal Employee Health Benefits Program. Or the federal government could widen current exemptions from state mandates for self-insured company plans to include any plan that complies with the insurance requirements of the Heritage proposal.[4]

- ✘ **Place requirements on employers:** In a system based on the Heritage proposal, employers would be required by law to do two things:

  1) **"Cash out" benefits during a one-year transition period.** Employers would have to add the cash value of their existing plan to the paychecks of any employee wishing to switch to an alternative plan or if the employer decided to terminate the plan. This means employees would be what economists call "held harmless" by the change. After

4 Heritage analysts believe that today's concerns about state mandates actually would decline or even disappear in a full-scale consumer based system. The reason is that voters would have a strong incentive to resist new insurance mandates since these would translate directly into higher insurance premiums they would pay. Today the higher costs due to mandates are buried in "free" company plans. Significantly Congress, which could mandate services in the federal employee system, chooses not to do so in large part because employees would face higher premiums if there were congressional mandates. See Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.

the transition, employers and employees would bargain for compensation packages as they do today.

2) **Introduce a payroll deduction for health insurance and adjust withholdings.** Employers would be required to make a payroll deduction each pay period, at the direction of each employee, and send the amount to the plan of the employee's choice. This would be like the payroll deduction that many employees instruct their employers to make for contributions to a 401(k) or similar savings plan. In the federal employee health system, a worker's agency or congressional office makes a similar payroll deduction to pay for premium costs.

Employers also would be required to adjust the employee's withholdings to reflect their estimated health credit, just as they do now when, say, an employee buys a house and becomes eligible for the mortgage deduction. This means that employees would not have to wait until the end of the year to claim the credit.

Q: What about a low-paid worker who does not have taxes withheld?

A: Actually even the low-paid normally have Social Security taxes withheld. In any case the employer would estimate the refundable credit available to the employee and send this, plus any contribution by the employee, to the employee's chosen plan. The employer would adjust the total withholdings sent to the IRS to reflect refundable credits for any employees.

Q: What about the unemployed?

A: If an individual became unemployed, normally he or she would become eligible for a larger credit, since family income would fall. For the unemployed, the government would send the value of the credit to the individual's plan. In addition, the unemployment check could be adjusted to reflect the contribution, if any, due to the plan by the individual. Further, since the paperwork for this change in the payment method would take time, health plans would not be permitted to drop coverage if a working family became unemployed. When the paperwork is complete, the plan would receive premium payments due during the interval.

ADVANTAGES OF THE HERITAGE PLAN

A consumer-based plan would have profound and beneficial effects on America's health care system. Among the most important:

✓ **Every American family would have access to affordable and adequate health care.**

Under the Heritage plan, all Americans—most important, all Americans now uninsured—would be enrolled in a health plan or covered by a public program (chiefly Medicaid or Medicare programs).

✓ Americans no longer would lose coverage when then they changed jobs.

American families would be able to obtain health coverage from any source, not just their employers, with exactly the same tax benefits. This means health insurance would be "portable." So when a worker changed jobs, he or she would take the family's health plan to the next job, just as they normally keep the same life insurance protection or mortgage company. For this reason, worries about "pre-existing condition" clauses in a new employer's plan would disappear, and families would keep the same doctor and benefits of their chosen plan.

✓ Americans could choose new kinds of group plans.

The fact that individuals will buy health plans does not mean that individuals must buy the kind of individual coverage typically sold today. Individual plans today tend to be more expensive for a number of reasons. Their administrative and marketing costs, for instance, are high because the insurer has to collect premiums from each individual. Group plans, such as those run by employers, cost less because the insurer is dealing in "bulk" and can negotiate with medical institutions.

Under the Heritage proposal, families could still gain the financial advantages of group purchasing. They could still join groups structured around their employer. More important, families could join plans organized by other groups and still receive tax benefits. Today, of course, if families are not part of an employer group plan, typically the families enjoy no tax benefits. Several new types of group probably would emerge. Among them:

Unions

Under the federal employee system, 35.5 percent of enrollees are covered in plans organized by a union or other employee organization. In many instances, these union plans are open to non-union members.[5] Sometimes the union health plan is much larger than the union itself. There are about 500,000 members of the Mail Handlers Plan, for instance, but only about 30,000 regular members of the union.

Union-sponsored plans likely would become a growth industry under the Heritage proposal. They would possess a marketing advantage because many workers would trust a union-sponsored plan rather than one from most other sources, particularly one promoted by management. Unions might also see a health plan as a good recruiting tool for attracting individuals as regular members. Further, many unions already have expert health benefits negotiators who could easily become the administrators of the union's own plan.

5 Technically, enrollees pay a small fee to become associate members of the union for the purposes of coverage, but are in no sense regular union members.

Churches

In many communities the church easily could sponsor a group health plan. This is especially true in the black community, where typically the church already functions as a social and economic development agency. Similarly, the Church of Jesus Christ of Latter Day Saints (that is, the Mormon church) carries out a sophisticated social welfare function for its members. Sponsoring a health plan for members would be a natural development.

Farm bureaus

Some state farm bureaus, such as Virginia's, already have a health plan for farm-based families. But often families receive limited or no tax breaks for joining such plans. With the Heritage proposal as law, farm bureaus and similar organizations would have a natural market niche in rural areas, especially for seasonal or casual workers.

Sickness groups

In some cases, a family might choose a plan offered by an organization of individuals suffering from a particular ailment. Many such organizations exist and give advice on obtaining treatment. Making a plan available to members would be a simple step. These plans, moreover, would structure medical services around the particular needs of the member, say a diabetic. Today, a diabetic typically has to take a standard company-sponsored plan containing items he or she does not use and then pay out-of-pocket for additional specialized services.

✓ Costs would be controlled effectively and efficiently.

The Heritage plan uses the best device ever found to hold down costs without sacrificing quality and efficiency: consumer choice within a competitive market. This works well and simply in the huge Federal Employee Health Benefit System, where cost increases are running at about one-third to one-half less than increases in company-sponsored plans.[6] It also works well in non-company insured markets, such as cosmetic surgery. It also works in every other private sector of the economy.

The Heritage plan would permit it to work in health care. Families would "shop around," comparing the premium prices and benefits of rival plans and making their choice accordingly, just as they do for life insurance, a car or a house, or college education for their children—and as federal workers do for health plans. Premium costs would be reduced by virtue of the tax credit, but families would still save money by choosing the least expensive plan that met their needs. In turn, plan organizers would have to compete aggressively for the family's dollars by developing plans that combined attractive benefits with a

6 See Moffit, *op. cit.*

good price—precisely the same imperative that keeps costs under control elsewhere in the economy.

✔ **The Heritage plan is budget neutral.**

The Heritage plan would not increase the federal deficit. This means that it is budget neutral. This is because the new credit system would cost the same as existing tax breaks for health care. As explained below, the plan also is budget neutral for states.

Q: Does a system based on the Heritage proposal have to be budget neutral?

A: **No.** But the basic plan could be made more generous to, say, the lower-paid by additional help from a state or the federal government. This, of course, would mean an extra cost to the budget.

DETAILS OF HOW THE HERITAGE CONSUMER CHOICE HEALTH PLAN WOULD WORK

The Heritage Foundation contracted with Lewin/ICF to construct a model of the plan within the framework of Lewin's econometric model of the health care economy. Lewin/ICF conducts econometric analysis for government and the private sector and is among the most highly respected companies in the field of health analysis. For purposes of this model, Lewin made small modifications, some to enhance the basic plan and others to simplify the modelling process. This required various assumptions and produced specific results.

✔ **How the tax credits would be structured**

Lewin/ICF modelled three versions of the basic Heritage plan. Other versions are of course possible. In each version, Lewin calculated the credit percentages that would result in budget neutrality for the federal government and the states. These are presented in Table 1. Minor adjustments could be made in the rates to produce more rounded numbers without departing significantly from budget neutrality.

Version #1 is a voucher plus a flat credit for remaining insurance and out-of-pocket costs. Each individual in a family would qualify for a refundable credit to help buy insurance. This "health insurance voucher" would be equal to a maximum of $220 per individual per year (80 percent of $275) or $880 for a family of four. In addition, the family could claim a flat 18 percent refundable credit for all insurance costs and out-of-pocket costs above $275 per year per individual (that is, above the amount subject to the voucher).

Version #2 is a sliding scale credit for all insurance costs and out-of-pocket costs. In this version, families would receive a sliding scale credit to help offset the cost of insurance and out-of-pocket costs. As these costs rise as a proportion

Table 1

Federal Tax Credit Alternatives

Tax Credit Version #1

- 80 of the cost of premiums up to $275 per family members, plus
- 18 percent of premiums over $275 per member, plus
- 18 percent of umreimbursed medical expenses.

Tax Credit Version #2

Premiums and Unreimbursed Expenses as a Percent of Gross Household Income	Percent Reimbursed Under the Credit
Below 10%	21%
10% - 20%	45%
20% or more	65%

Tax Credit Version #3

- 75 percent of premiums up to $275 per family member, plus
- 14 percent of premiums over $275, plus

Unreimbursed Expenses as a Percent of Gross Household Income	Percent Reimbursed Under the Credit
Below 10%	21%
10% - 20%	45%
20% or more	65%

Note: The credits are refundable.
This structure of credits is budget neutral at the state and federal levels.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

of family income, the percentage credit also would rise. The structure of this sliding scale credit is much like the child care credit in today's tax code.

Version #3 is a combination of the first two. A voucher and flat rate credit would apply to insurance costs only, and a sliding scale credit to out-of-pocket costs. This version would encourage families to buy a basic plan, but give them a bigger incentive to accept higher deductibles and copayments.[7]

✓ The minimum benefits package required by law

Table 2 indicates the minimum benefits package that would be required by law under the Heritage proposal, as chosen by Heritage analysts and priced by Lewin/ICF. For a family of four this plan is estimated to cost $277.33 per month or $3,327.84 per year, so it is by no means a "bare bones" plan. It should be noted that the plan has been priced on a per capita basis. In practice family plans cost less than the total would be if each member bought a separate plan. So the cost for a family in the model is probably an overestimate in some cases. Equivalent coverage options would be permitted. For instance, instead of 75 percent coverage for physician services, a plan may have a higher percentage, but a

Table 2
Basic Plan Required by Law

Minimum standard coverage required for all Americans.

- $1,000 deductible ($2,000 per family).
- $5,000 cost-sharing maximum.

Benefit	Coinsurance
Inpatient Hospital Services (365-day per stay maximum)	80%
Outpatient Hospital Services	80%
Hospital Alternatives (extended or home health care)	Yes
Physician Services	75%
Prenatal/Well-Baby/ Well-Child Care	75%
Diagnostic Tests	75%
Prescription Drugs (inpatient)	75%
Emergency Services	100%
Mental Health Care	Not Covered
Dental Care	Not Covered
Vision Care	Not Covered

Average monthly cost of the plan is $69.33 per person.

Actuarial equivalent alternatives are permitted.

Note: Individuals covered by a government health program such as Medicare and Medicaid are exempt from those coverage requirements.

Actuarially equivalent plans are ones with different coverage or benefit levels than those specified here, but whose total cost is the same for individuals with the same actuarial characteristics such as age, sex, and geographic location.

7 A copayment, or coinsurance, is the percentage of an otherwise insured medical bill that must be paid by the patient.

lower percentage for inpatient prescription drugs. A prepaid managed health plan (such as a Health Maintenance Organization, or HMO) with at least the same basic coverage would be permitted.

The legally-required basic plan would limit deductibles for a family to no more than $2,000 and total unreimbursed costs (including the deductible) to no more than $5,000, often known as the "stop loss" amount or amount above which there is "catastrophic" protection. A family could choose a plan with a lower deductible or catastrophic protection, but normally that would mean a higher premium. These unreimbursed medical costs would be offset by a credit in each version of the Heritage plan (they are not normally given tax relief today) and so would be less costly to a family than the same amounts included in a company-sponsored plan today.

✓ The employer's responsibility

Table 3 summarizes the responsibility of employers. In essence employers act as bookkeepers for their employees, handling premium payments and tax adjustments on the employee's behalf. One important assumption is made about Social Security (FICA) tax. If employer-provided plans become subject to tax (offset, of course, by the new credit), the value of those benefits also would become subject to the "employer's share" of Social Security tax. Heritage analysts instructed Lewin/ICF to assume in modeling the plan that in con-

Table 3
The Employer's Responsibiliy

Employers have the option of:

- Continuing to provide health benefits; or
- Discontinuing the health plan.

For employers who continue to provide benefits:

- The average amount of the employer's contribution is counted as taxable income to the employee.*
- Employees may not take cash in lieu of coverage.

For employers who discontinue coverage:

- Employers must maintain their current level of effort by converting benefits to income.
- Employers must deduct premiums for workers.

Employers will hold workers harmless for the employer share of increased FICA tax payments due to taxation of benefits.

* Separate employer contribution amounts would be used for persons with single and family coverage.

verting current benefits to cash during the transition year, employers pay this extra tax (see below). Other than this small tax, there would be no change in taxes or total employee compensation costs for an employer.

✓ Changes in the insurance market.

Table 4 indicates the proposed reforms of the insurance market under the Heritage Consumer Choice Plan. The most important of these is that all health plans henceforth would be required to guarantee annual renewal for any enrollee who wished to do so, with a premium increase no greater than the average for all enrollees covered by the carrier. This means that insured individuals could not be dropped, or charged unduly high premiums, if they became sick. In addition, under the Heritage plan, three underwriting requirements would be placed on insurance companies—at least during a transitional period while the insurance market adjusted to the new financing system.

First Requirement: Uninsurable Americans (those for whom insurance is impossible in a free market except at prohibitive prices) who are currently uninsured would be randomly assigned to insurers and plans doing business in a state. This would spread the cost of insuring high-risk families among existing plans.

Second Requirement: If an insurer now covers a family, say through a employer-based plan, that insurer would be required to continue coverage if the employee wished it. This means a sick person now in a company-sponsored plan would not be dropped if the employer ended the plan or the employee moved. The insurer would be required to convert the group coverage to individual coverage, so the worker would not lose coverage if he or she changed jobs.

Table 4
Insurance Market Reforms

Reform of renewal practices.

- ❐ Guaranteed renewal.
- ❐ Renewal Premium updated by carrier-wide average increase.
- ❐ Changes in premium due to changes in health status are prohibited.

Current marketing/underwriting practices modified during at least the transition period.

- ❐ Uninsurable individuals who are currently uninsured are randomly assigned to carriers.
- ❐ Insurers must extend portable, individual coverage to all persons they now cover through employment-based group plans.
- ❐ In converting from group to individual coverage, premiums are permitted to vary by no more than 25 percent on the basis of age, sex, and geography-adjusted premiums.

State mandates are preempted by standard benefit package.

State Laws restricting selective contracting and managed care plans are preempted.

Third Requirement: Plans could not charge more than 25 percent above or below the average charged for new enrollees with similar characteristics. This means that sick families, who today often find the cost of coverage prohibitive, could not be charged premiums more than 25 percent above those for similar families of average health. If a family switched plans, moreover, the new carrier could not charge them more than 25 percent above the average premium charged for similar families.

✔ Modelling assumptions made by Lewin/ICF

Lewin/ICF had to make certain assumptions about consumer behavior and other features of the basic Heritage plan to "run the numbers." Some of these are crucial; others simply were to ease the process of modelling and could be changed in any final program. These are contained in Tables 5 and 6. Among the most important:

First Assumption: All employers are presumed to discontinue their existing plans and convert their value into additional cash income for employees. This makes the calculations easier and more reliable, but is not crucial to the plan. Some large companies might well continue to provide coverage.

Second Assumption: Healthy families buy a basic plan and pocket the savings, while currently insured Americans in poor or fair health either maintain their existing coverage or upgrade to better coverage. The model assumes all the uninsured buy the basic package, which includes catastrophic protection (although some doubtless would buy more elaborate plans).

Table 5
Key Assumptions

Employers who now offer insurance:

- All will discontinue coverage and convert benefits to wages.
- Firms with over 1,000 workers establish employee premium financed cafeteria plans, which will reduce administrative costs.

Workers now covered by employer insurance:

- Those in poor/fair health will select plans that at least maintain their existing level of coverage.
- Those in good/excellent health will downgrade to the standard package.
- Health services utilization for persons who downgrade coverage will decline based upon price elasticities reported in the literature (a price elasticity of -0.2 was selected).

Persons now covered by non-group insurance:

- Persons who now have coverage in excess of the minuimum standard will maintain that coverage.
- Others will upgrade to the minimum standard.

Currently uninsured persons:

- All will take the minimum standard package.
- Utilization will adjust to levels reported by insured persons with similar charactoeristics.

No change is assumed in the number of persons enrolled in Medicaid.

Third Assumption: Administrative costs are assumed to be lower than for today's individual health insurance plans. However, Lewin/ICF does not assume that all employers would make a payroll deduction for employees and send premiums to the chosen insurer. In fact, Heritage analysts make that a legal requirement. This might mean somewhat lower administrative costs than Lewin/ICF projects.

Table 6

Administrative Cost Assumptions

Administrative costs would be the same as under current policy for workers in firms where the employer arranges employee deductions.

Administrative costs for others purchasing individual insurance would be 21.9 percent of claims. This retention rate was estimated as follows:

Administrative Costs for Individual Coverage as a Percentage of Claims

	Current Policy[a]	Assumed level Under Tax Credit[b]
Claims Administration	9.3%	8.0%
General Administration	12.5	10.0
Interest Credit	-1.5	-1.5
Risk and Profit	8.5	2.7
Commissions	8.4	0.0
Premium Taxes	2.8	2.7
Total	**40.0%**	**21.9%**

a: Hay/Huggin estimates of administrative costs for groups with 1 to 4 members under current policy.

b: Hay/Huggin estimates of administrative costs for groups with 1 to 4 members under a voluntary risk pooling arrangement adjusted to assume that insurer profits as a percent of claims correspond to the national average observed in the current system.

Source: Congressional Research Service, "Cost and Effects of Extending Health Insurance Coverage," Washington, D.C. October 1988.

HOW TOTAL SPENDING WOULD BE AFFECTED

Effect #1: Total U.S. spending on health care would fall immediately by $10.8 billion. Families initially would save $18.8 billion.

Households would pay directly for their own coverage under the Heritage plan, rather than have their employer paying for it as happens today. As a result, total household health payments would, in the first instance, go up substantially. But the cost would be more than offset by two items, as indicated in Table 7: the tax credit (worth a total of $84.9 billion), and the increase in wages due to firms cashing out existing benefits (for a total increase in cash wages of $148.7 billion). This would leave families as a whole ahead by $18.8 billion. Private employers, as well as federal, state and local governments, would save on health costs, but pay their employees more in cash income. The net effect on total health spending, concludes Lewin/ICF, would be a reduction of $10.8 billion.

Q: Would this one-time saving be all the cost reduction under the Heritage plan?

A: No. Lewin/ICF does believe that the pattern of spending after these changes would continue in line with today's trend. However, Heritage analysts believe the new incentives for families to shop around for the best bargain would hold the annual growth of spending significantly below current trends. If the general increase were to be held to the rate in recent years of the consumer-based Federal Employee Health Benefits Program, for instance, American families would save tens of billions of dollars each year in health costs, with bigger savings each year compared with current projections.

Table 7

Change in National Health Spending by Source of Payment

(billions of dollars)

	Subtotals	Change in Spending
Impact on Payors		
Household Payments		$129.9[a]
Premium Payments	$88.2	
Out-of-Pocket Spending	62.7	
Tax Credits	(84.9)	
Eliminate Tax Exclusion	63.9	
Private Employers[b]		(112.4)
Federal Government[b]		(5.1)
State Governments[c]		(23.2)
Net Change in Health Spending		
Changed in Health Spending		(10.8)
Utilization for Newly Insured	8.9	
Utilization for Currently Insured	(21.8)	
Insurer Administrative Costs	2.1	

Note: Figures indicate increase in spending. Reductions in spending are in parenthesis.

a The increases in household health spending will be offset by increased wages of $148.7 billion.

b Reflects elimination of employee coverage. Employer savings in health spending will be offset by increases in wages not shown here.

c Reflects elimination of employee coverage and savings to county hospitals.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Effect #2: The plan would be budget neutral at the federal and state levels

The Heritage proposal is budget neutral. Tables 8 and 9 indicate the impact in federal and state revenues. Significantly, the states would enjoy a windfall of $13.2 billion by cutting costs at public hospitals that treat the uninsured. These uninsured would now be covered by insurance partly financed with a tax credit. States with income taxes also would receive extra taxes since taxable wages would rise because of the elimination of the tax exclusion for company plans. To preserve budget neutrality at federal and state levels, the Heritage plan assumes that the states make a contribution to the federal tax credit equal to their net savings.

Q: How would the states contribute to the federal credit?

A: One way could be through a reduction in the federal share of funding for the federal-state Medicaid program, or reductions in other federal health grants to states. This makes sense because the federal credit would help lower-paid state residents to afford care, thus relieving the health care costs of a state. The Bush Administration's proposed low-income health credit would be financed in part in this way. Another method would be to require states to make a contribution to the credit (such as being responsible for a fixed dollar amount of the insurance voucher in versions #1 or #3 of the Heritage plan).

Table 8

Sources and Uses of Federal Funds Under the Tax Credit Program in 1991

(in billions of dollars)

Sources of Funds			Uses of Funds		
Elimination of Tax Exclusion			**Tax Credits**		**$84.9**
Federal Income Tax	39.7		**Civil Service Plan (FEHB)**		
OASDI Payroll Tax	21.2		Health Benefits	(4.6)	
HI Payroll Tax	5.7		Wages	4.6	
		$66.6	OASDO and HI Taxes	0.5	
					0.5
Eliminate Deduction for Health Expenditures in Excess of 7.5 percent of AGI		**2.5**	**Corporate Income Tax Loss***		**2.5**
Contribution from State and Local Governments		**18.8**			
Total Sources of Funds		**$87.9**	**Total Uses of Funds**		**$87.9**

Note: Number in parenthesis represent negative amounts.

* We assume that the full amount of the employer share of the increase in OASDI and HI payroll taxes is absorbed by employers as reduced profits resulting in a change in corporate income tax payments.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Q: Could states introduce their own health credit?

A: Yes. In fact a credit in a state's tax code would be a logical addition to the basic federal plan. Several states, including Maryland and Minnesota, already are considering a state health tax credit.

Q: Could states add funds to the plan to give more help to the low-paid?

A: Yes. In one version of the Heritage proposal, Lewin/ICF was asked to assume that each state would supplement the federal program with a program to cover the expenses of any family that, despite the federal credit, faced out-of-pocket costs of more than 20 percent of its income. In modeling this version, states were given discretion in how they would structure such additional assistance. Taking together the various savings to states and local governments, thanks to the federal credit and tax changes, Lewin/ICF calculated that the new program would cost state and local governments $6.7 billion more than they now spend on health care. In this variant of the plan, the states would not contribute to the cost of the federal credit. Thus for federal budget neutrality, the federal credits would have to be less generous.

Table 9

Sources and Uses of State Funds Under the Tax Credit Program in 1991

(billions of dollars)

Changes in Revenues			Changes in Expenditures		
Elimination of State Income Tax Exclusion[a]		**$8.3**	**Public Hospitals**		**($13.2)**
Premium Taxes[b]			**State and Local Worker Benefits**		
Current Revenues	(1.6)		Health Benefits	(23.8)	
Revenues Under Policy	1.5		Wages	23.8	
		(0.1)	OASDI and HI Taxes	2.0	
					2.0
State Corporate Income Tax Loss		**(0.6)**	**Contribution to Federal Tax Credit**		**18.8**
Net Change in Revenues		**$7.6**	**Net Change in Expenditures**		**$7.6**

Note: Number in parenthesis represent negative amounts.

a The increase in wages under the program will result in an increase in state income tax payments.

b Premium tax revenues decline due to the reduction in the value of health insurance coverage under the tax credit program.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Effect #3: With all the changes employers would pay less than $10 a month extra per average employee.

Table 10 shows the bottom line for employers. Employers would be required to pay the "employer's share" of the Social Security tax payable on "cashed out" health benefits returned to the employee as extra wages. On the other hand, this extra tax would reduce profits and thus corporate income taxes. The net effect would be an annual increase in costs to employers averaging $104.80 per employee (or just $8.73 per month).

Table 10
Change in Employer Health Spending Under the Tax Credit Program in 1991
(billions of dollars)

		Change in Spending
Current Employer Expenditures for Health Care[a]		$124.3
Convert Employee and Dependent Benefits to Wages[b]		0.0
Benefit Payments	(120.2)	
Wages	120.2	
OASDI and HI Tax on Benefits (employer share)		10.9
Change in Employer Costs		10.9
Change in Corporate Taxes[c]		(3.1)
Net Change in Employer costs (Change in costs per worker of $104.8 per year)		$7.8

Note: Number in parenthesis represent negative amounts.
a Includes the employer share of expenditures for workers, dependents, and retirees.
b Employer contributions for worker and dependent benefits are converted to wages. Retiree coverage is assumed to be retained.
c The entire amount of the increase in OASDI and HI payroll taxes is assumed to be absorbed by employers as reduced profits resulting in a change in corporate income taxes.
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

WHAT THE HERITAGE PLAN MEANS FOR TYPICAL FAMILIES

Impact 1: As a whole, American families would save $18.8 billion in the first year of the plan, and would not lose coverage if they changed or lost their job.

Table 11 indicates the aggregate impact of the plan on American households not on Medicaid or Medicare. Families would be affected in several different ways. Since families would select and pay for their own health plan, typical workers would pay more in premiums as well as out-of-pocket costs. They also

would lose the tax exclusion for any company-provided benefits. Yet, they would also receive extra income, because employers would be required to give them cash instead of benefits and they would receive a new tax credit to replace the tax exclusion. The net effect is that working age households would have a total of $18.8 billion more in their pockets after all these changes. They would also be able to choose their own health plan and keep it if they changed jobs.

Table 11

Change in Household Health Spending Under the Tax Credit Program in 1991

(billions of dollars)

Health Spending		
Premium Payment		$88.2
Employee Contribution in Employer Plans	(45.2)	
Individual Premium Payments	133.4	
Out-of Pocket Expenses		62.7
Tax Credit		(84.9)
Eliminate Tax Expenditures (individual share)		61.4
Federal	53.1	
State	8.3	
Eliminate Health Expense Deduction (over 7.5% AGI)		2.5
Net Change in Health Spending		129.9
Wage Effect		
Increased Wages (offset to change in health spending)		(148.7)
Net Impact on Households		($18.8)

Note: Number in parenthesis represent negative amounts.
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Impact 2: A family with an annual income below $50,000 typically would receive higher tax breaks for its health care plan.

Table 12 shows how the value of tax breaks for health coverage would be affected for typical households.[8] Today the typical family earning less than $10,000 gets just $50 a year in tax relief under the tax exclusion system. Under version #1 of the Heritage plan, this family would receive $372 more in (refundable) tax benefits and $684 more under version #2. A family earning over $50,000, but less than $75,000, would lose just $13 in tax breaks under version 1, or just over $1 a month. Families as a whole would receive more federal tax relief under the plan than they do because health cost savings to the states would be added to the funds to finance the new credit.

8 All figures cited here from Tables 12 and 13 are averages for all families within income class.

Table 12

Average Change in Federal Tax Benefits for Families by Income Under the Tax Credit Plan in 1991

	Current Tax Exclusion	Net Change in Tax Benefits: Tax Credit Version #1	Tax Credit Version #2	Tax Credit Version #3
Family Income				
less than $10,000	$ 50	$ 372	$ 684	$ 476
$10,000 - $14,999	207	462	664	517
$15,000 - $19,999	366	444	612	487
$20,000 - $29,999	594	365	451	372
$30,000 - $39,999	857	365	401	388
$40,000 - $49,999	986	256	182	248
$50,000 - $74,999	1,373	(13)	(232)	(84)
$75,000 - $99,999	1,427	(32)	(345)	(129)
$100,000 or more	1,463	47	(285)	(55)
All Families	$ 802	$250	$250	$250

a Includes federal income taxes and the employer and the employee share of the OASDI and HI payroll taxes.
b The tax credits are structured to be budget neutral
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Q: Does the Heritage plan mean, as some have charged, that families would lose tax relief for their health benefits?

A: No. Only the method of tax relief would change—from tax-free company plans to a refundable tax credit. Indeed, as Table 12 shows, most families would receive larger tax breaks for health care.

Impact 3: In version #1 of the proposal (voucher with flat 20 percent credit), typical families with annual incomes between $15,000 and $100,000 would pay less, after taxes, on health care than they do today. All families could choose their health plan and it would be portable.

Chart 13 shows the net change in federal taxes broken down by income level. The top row indicates the value of the current tax break for employer-paid insurance. The next three rows show the change in health costs when the current tax exclusion is eliminated and the next row computes the increases in wages when current benefits are converted to cash.

The next three rows show the typical refundable tax credit for each version of the Heritage proposal. The final three rows show the "bottom line" for each family broken down by income. These rows indicate the net change in a family's health care spending compared with the current system. Figures in parentheses indicate a reduction in spending compared with today. For this bottom line, the family now would have at least a basic plan of their choice that they could take from job to job, with a limit on total out-of-pocket costs.

Table 13

Average Net Impact of Alternative Tax Credit Options on Families by Income (1991)

	All Households	Family Income								
		less than $10,000	$10,000 - $14,999	$15,000 - $19,999	$20,000 - $29,999	$30,000 - $39,999	$40,000 - $49,999	$50,000 - $74,999	$75,000 - $99,999	$100,000 or more
Household Health Spending Under Current Law	$1,841	$887	$1,223	$1,428	$1,638	$2,106	$1,954	$2,295	$2,400	$3,238
Changes in Health Spending										
Change in Premium Payments[a]	1,214	671	930	991	1,100	1,279	1,312	1,459	1,679	1,854
Change in Out-of-Pocket Payments for Care	692	108	286	367	519	769	990	1,059	1,053	1,176
Elimination of State and Federal Tax Expenditures[b]	745	35	154	283	500	736	875	1,330	1,397	1,492
Wage Effects										
Increased Wages (counted as an offset to health spending)	(1,767)	(162)	(657)	(1,119)	(1,531)	(2,060)	(2,313)	(2,681)	(2,754)	(2,770)
Tax Credits (Federal and State)										
Version #1	(1,052)	(422)	(669)	(810)	(959)	(1,222)	(1,242)	(1,360)	(1,395)	(1,510)
Version #2	(1,052)	(734)	(871)	(978)	(1,045)	(1,258)	(1,168)	(1,141)	(1,082)	(1,178)
Version #3	(1,052)	(526)	(724)	(853)	(966)	(1,245)	(1,234)	(1,289)	(1,298)	(1,408)
Change in After-Tax Health Spending Net of After-Tax Change in Income										
Version #1	(168)	210	44	(288)	(371)	(498)	(378)	(193)	(20)	242
Version #2	(168)	(82)	(158)	(456)	(457)	(534)	(304)	(26)	293	574
Version #3	(168)	126	(11)	(331)	(378)	(521)	(370)	(122)	77	344

Note: Figures in parenthesis represent negative numbers.

a Includes individual premium payments less employee contributions to employer plans eliminated under the tax proposal.

b Includes the additional taxes paid on employer benefits converted to income including: federal income taxes; the employee share of OASDI and HI payroll taxes; and state income taxes.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Impact 4: In version #2 of the proposal (a sliding scale credit), typical families with annual incomes below $75,000 would pay less, after taxes, on health care than they do today. All families could choose their health plan and it would be portable.

See Table 13.

Impact 5: In version #3 of the proposal (voucher with sliding scale credit), typical families with annual incomes between $10,000 and $75,000 would pay less, after taxes, on health care than they do today. All families could choose their health plan and it would be portable.

See Table 13.

Impact 6: Case studies of typical families under the Heritage plan are given below.

SELECTED CASE STUDIES

Case #1: A young two-parent farm family with one child and has a family income of $25,000 per year. The family has no insurance and average health. In a typical year pays out $1,500 in essential hospital and doctor bills, but has no major medical protection.

Under the Heritage plan, this family selects a basic plan offered through their state farm bureau. The plan costs $2,500 and the family pays $500 in out-of-pocket expenses.

	Today	Under Heritage Proposal
Tax relief for health	0	$1,051
Extra cash income		0
Net extra taxes paid under Heritage proposal		-1,051
Change in disposable income after tax changes and health spending under Heritage proposal	N/A	-449*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #2: A young single blue-collar worker in excellent health currently works for a major industrial company and earns $21,000. The worker currently has an employer-paid health plan with no deductible worth $3,000 per year.

Under the Heritage plan, the worker switches to a basic plan sponsored by his union. For this plan he pays $850 and he pays out $450 in out-of-pocket costs. The employer adds $3,000 to his paychecks over the year and makes a payroll deduction equal to the premium for his union plan and sends the money to the union.

	Today	Under Heritage Proposal
Tax relief for health	$450	$ 404
Extra cash income		3,000
Taxes on extra income	N/A	450
Net extra taxes paid under Heritage proposal	N/A	46
Change in disposable income after tax changes and health spending under Heritage proposal		+1,654*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #3: An engineer, aged 50, with a manufacturing company has a non-working spouse, two children, and a typical history of health problems. Currently he earns $45,000 and has a company-paid plan. The company pays the premium of $6,000 and the family pays out the full $600 each year in deductibles and copayments. This year, however, the company has decided to lay off the worker. Although he fortunately has the offer of another job paying the same total compensation of $51,000 ($45,000 + $6,000) with a small engineering firm, that firm says it will not give part of the compensation in the form of health benefits, because it cannot arrange affordable group coverage. So he faces the prospect of being uninsured.

Under the Heritage proposal, he elects to continue his current plan, converted to individual coverage for his family and paid for by himself. The plan will cost the same premium with the same deductibles and copayments.

	Today (old job)	Under Heritage Proposal (new job)
Tax relief for health	$1,254	$1,870
Extra cash income		6,000
Taxes on extra income	N/A	1,254
Net extra taxes paid under Heritage proposal		-616
Change in disposable income after tax changes and health spending under Heritage proposal		+616*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #4: A two-earner professional family, with one child, earns $130,000 per annum. The family is covered under the father's policy, which is paid by his employer and is worth $7,000. The family pays a deductible of $600. In addition, the family has mortgage interest payments and other deductions of $30,000 per year.

Under the Heritage plan, the family decides to take the $7,000 value of its current plan in cash and instead buy a less comprehensive policy with a $3,000 premium and out-of-pocket costs of $1,500.

	Today	Under Heritage Proposal
Tax relief for health	$2,235	$1,321
Extra cash income		7,000
Taxes on extra income		2,235
Net extra taxes paid under Heritage proposal		914
Change in disposable income after tax changes and health spending under Heritage proposal	N/A	+2,186*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

COMMONLY ASKED QUESTIONS ABOUT THE HERITAGE CONSUMER CHOICE HEALTH PLAN

Q: Are American families capable of choosing health plans?

A: Yes. About 9 million federal workers and federal retirees do so every year under the Federal Employee Health Benefits Program (FEHBP).[9] These workers include mail room clerks, janitors, and messengers, as well as professional economists, congressmen and cabinet secretaries. In the Washington, D.C., area they choose from among over thirty plans. They can make choices because consumer organizations, the local press, their family doctors, employee organizations, and other groups supply them with "user friendly" information on which to base their choices. The same kinds of information would quickly mushroom for 100 million American households choosing health plans as exists today to help these households buy a car, a house, or a mutual fund.

Q: How would costs be controlled?

A: In the same way as they are controlled in the automobile or computer market—by cost-conscious consumers buying a product from among competing suppliers. Critics of consumer-based cost control claim that families cannot question the cost of specialized medical procedures. But this ignores the way consumer choice would work. Most Americans know little about carburetors or steering systems in an automobile. If they bought a car by purchasing all the components individually from different firms the car no doubt would be very expensive, and would not run well. Instead they buy completed cars from among rival assembly firms. In turn these firms bargain for quality and price from component makers.

Essentially the same process would operate in a consumer-based health system —and does so today in the FEHBP. Families would choose among competing plans. The plan organizers, not the families, would bargain with doctors and hospitals to keep costs down. That system of consumer choice and competition has enabled the FEHBP to keep its premium increases well below those of private employer-sponsored plans.

Q: How would the obligation to buy insurance be enforced?

A: In two ways. Taxpayers would have to attach proof of insurance or enrollment in a public program to their tax return or face a fine. In addition, employees would have to furnish their employers with proof of insurance, which would be forwarded to the government. Those unable to show they had

9 See Moffit, *op. cit.*

coverage might be assigned to Medicaid by the state but billed for all or part of the cost of coverage. To be sure, some individuals still would evade the law, but the number is likely to be small.

Q: Would the Heritage plan foster lower-cost managed care plans?

A: It probably would, but only because families freely chose managed care in a competitive market. In the consumer-choice Federal Employee Health Benefits Program, federal workers choose HMOs (a form of managed care) at about double the national rate. But managed care would not be artificially encouraged, as some reform plans would do. If a more efficient form of health care delivery were to emerge and satisfy consumers, it would win customers under the Heritage proposal.

Q: What would happen to the very sick under the Heritage plan?

A: They would be able to purchase a plan of their choice at no more than 25 percent higher premiums than similar families with normal health, and they would have the right to renew the plan each year without premium increases any larger than those for healthy individuals in the plan. They would receive a higher tax credit to offset part of this higher premium. Today they are often unable to obtain insurance.

Q: What about the very healthy?

A: Typically they would opt for a "lean" basic plan and enjoy higher after-tax incomes. Today they are typically overinsured and tend to adopt a "use it or lose it" attitude to health services. Further, the healthy and wealthy would pay higher taxes, which would pay for the cost of generous credits for the poor and sick. But this does not mean the healthy and wealthy would object. They simply would take less of their income in insurance coverage and more in (taxable) cash income for other uses—much like getting a taxable raise.

Q: Wouldn't some of the working poor pay more for health care under the Heritage plan?

A: As Table 13 shows, under versions #1 and #3 of the Heritage plan, lower-paid families typically could pay slightly more than they do today—although under the least-attractive version that would be an average of no more than $18 per month. But for this money the family now would have insurance, and insurance it could renew automatically each year and keep from job to job.

Further, as indicated earlier, states and the federal government could choose to increase the help given to the lower-paid. The federal government could change the tax credit formula, in a budget neutral way, to give extra help to the

poor by reducing the tax relief for middle and upper income families. Or if the federal government decided to increase net spending (or tax help) for health, it could make the credit more generous for the lower-paid. States could introduce their own budget neutral credit, or they could add funds to assist the lower-paid.

Q: What about those families on Medicaid?

A: Medicaid would not be affected directly by the proposal. Today a head of household on welfare typically has to give up thousands of dollars in Medicaid health benefits if he or she leaves welfare and takes a job without health benefits. But under the Heritage Plan, many families now on welfare (and Medicaid) would choose to take a job because a refundable credit for health care insurance would be available. This would reduce Medicaid and AFDC costs.

Q: What about those now on Medicare?

A: The basic Heritage plan does not change Medicare. However, it would be quite logical to allow working Americans to keep their health plans when they retire, with the federal government making a financial contribution to these plans in place of today's Medicare cumbersome reimbursement system. This "voucherizing" of Medicare would encourage retirees to shop for the best plan for their needs. The FEHBP operates in much this way for federal retirees.

Q: How does the Heritage plan differ from the Bush Administration's recent health reform proposal?

A: For those now uninsured, both plans are quite similar, except that the Bush plan gives a refundable credit only for the poor, and a deduction for non-poor uninsured families. But it would, like the Heritage plan, cover today's uninsured and enable them to obtain a "portable" plan. The Bush plan, however, would have little or no effect on the costs of company-provided plans, because it makes no changes at all in the tax treatment and so would not encourage employees with company-sponsored plans to seek better value for money.[10] There is also no explicit mechanism in the Bush plan to pay for its new credit and deduction.

Q: Does the Heritage plan have to be introduced all at once?

A: No. It could be phased in gradually. One first step might be to limit the tax exclusion for company-sponsored plans to, say, $4,000 per year for a family, and use the tax revenue to fund a credit for out-of-pocket health expenses ex-

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10 See Stuart M. Butler, "What's Right and Wrong with Bush's Health Plan," Heritage Foundation *Executive Memorandum* No. 321, February 7, 1992.

ceeding 5 percent of family income. In later years the exclusion limit could be lowered, and more generous credits made available.

CONCLUSION

The Heritage Consumer Choice Health Plan is a comprehensive reform of the American health care system designed to assure affordable access to health care for all Americans without an increase in taxes and with an improvement in the efficiency of the health care system.

Unlike the Canadian system preferred by some lawmakers, the Heritage plan would not institute government-controlled rationing and waiting lists. And unlike the "play or pay" system, it would not compound the problems of today's system with new payroll taxes and a huge new public program. Instead it would change the way government helps Americans to obtain care, making that help more equitable, and it would trigger in health care the same dynamic forces that secure quality and efficiency in the rest of the economy—consumer choice and competition.