HERITAGE TALKING POINTS

A Checklist on Vital National Issues

A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS

PART I: THE DEBATE OVER REFORM

By Stuart M. Butler, Ph.D.

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INTRODUCTION

The United States health care system has come under increasing criticism in recent years and is fast becoming a central issue in this year's national election. The reason: although the U.S. system has obvious virtues, there is widespread dissatisfaction with the system among ordinary Americans.

For most of these Americans, the quality of care is not the central problem. Indeed, the quality of the U.S. system is the envy of the world. People flock to America when they want the best—even people from Canada, despite its vaunted national health system. And Americans rarely go abroad for health care.

The chief concern of Americans, surveys show, is with the way in which health benefit plans are organized and financed. They worry about losing benefits when they change jobs or joining the ranks of the uninsured when they are laid off. They fret about being wiped out financially by a disease that is not covered by their plan or whose cost exceeds their coverage limits. They complain about the seemingly endless paperwork associated with even a minor insurance claim. And if they are employers, they are frustrated at their lack of success in trying to hold down exploding health benefits costs.

Fundamental Reform Sought. Various bills before Congress, as well as proposals under discussion around the country and a plan unveiled recently by the Bush Administration, seek fundamental reform of the U.S. health care system. Some would replace it entirely with a government-run system like that of Britain or Canada. Others would require all employers to provide at least a basic package for all their workers and their families, or pay a tax to fund government-organized health benefits for those without company insurance.

Others still, including a proposal from The Heritage Foundation, suggest a different approach. These proposals start from the premise that the health system is in such bad shape because the tax and regulatory treatment of health plans has distorted the health system in such a perverse manner that anything resembling a normal market has broken down. What these proposals would do is change the rules so that consumers would have the incentive and the means to choose the

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health plan they want, and the ability to afford at least a basic plan.

Under the Heritage Foundation Consumer Choice Plan, which will be discussed in Part II of this *Talking Points* series, the current tax break for employer-provided health benefits would be replaced with a tax credit for health plans or medical services obtained from any licensed source, not only an employer.[1] Like the other major approaches being debated, this relatively simple change would have profound effects on the health care system.

This *Talking Points* Part I examines the reasons for the concern about health care. It then summarizes and analyzes the major options for reform.

WHAT'S WRONG WITH THE U.S. HEALTH CARE SYSTEM?

The first thing to understand is that the U.S. health system actually is several systems. There are **government-operated** systems, such as the Veterans' Health Administration, in which hospitals are owned by the government and doctors are government employees. These are much like the core of the British National Health Service.

Then there are **government financed and regulated** systems—chiefly Medicare and Medicaid. According to the Congressional Budget Office, Medicare covers about 27 million elderly Americans (another 3 million disabled individuals also are covered) and Medicaid provides primary coverage for about 15 million non-elderly Americans. In these programs the government pays private doctors and hospitals set fees to treat certain individuals. These function much like the Canadian system.

Then, for the vast majority of working Americans, there is a system of **employer-sponsored private health insurance.** About 150 million Americans under the age of 65 are covered in these company plans.

Q. What is driving the calls for major reform?

A. While there are concerns about every sector in this system, the political debate today centers on the private insurance system. While most Americans do not fault the quality of the health care they receive from employer-provided health plans, they grumble loudly about other features. Among them: they can lose coverage or have worse coverage if they change jobs; employers always seem to want to cut benefits or make the employee pay more for coverage; mountains of paperwork accompany every claim.

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.

Q. So why do most Americans have company-provided plans?

A. It is a historical accident driven by two connected events. First, when wage controls were instituted during World War II, firms encountering severe labor shortages increasingly expanded fringe benefits, especially health benefits, to attract workers. Second, the Internal Revenue Service ruled after the war that such health benefits would, without limit, be free of federal income and Social Security tax. These events, not any national consensus that employers are the best people to organize health benefits, brought about the system that determines the health care available to most Americans.

Q. How does the tax law encourage employer-based plans?

A. Under current law, if a worker accepts a health package from his or her employer, the insurance element of that package is tax-free.[2] Any out-of-pocket payments by the employee (such as deductibles or items not included in the plan) are not tax-free and must be paid for in after-tax dollars.[3] If the employer does not provide insurance or the employee prefers some other plan, the employee gets no tax break for buying insurance or medical services himself.

Q. Why does this tax treatment cause problems?

A. The employment-based system artificially encouraged by the tax code leads directly to the problems commonly cited by Americans as the reasons why fundamental reform is needed. Among them:

Problem #1: If you change your job, you must change your health coverage; if you lose your job, you lose your coverage.

Because health insurance for most families is employment-based, when a worker changes or loses jobs, suddenly the family's health coverage changes or is lost. If the new employer provides insurance, it can mean a major change in benefits. Sometimes families lose benefits they like; often they will have to switch to a new doctor that is included in the new plan. Often a change of job can mean financial disaster. Even if coverage is available from the new employer, usually there are "pre-existing condition" clauses in the plan, meaning the family will not be covered for an existing illness. And if

2 Including cases where the employer "self-insures," that is, carries the insurance risk himself, and cases where the insurance takes the form of monthly payments to a pre-paid managed health plan, such as a Health Maintenance Organization (HMO). For self-employed individuals, only 25 percent of the cost of a plan is tax-free.

3 There are certain exceptions, the main one being a deduction available under Schedule A of the tax form (itemized deductions) for out-of-pocket costs that exceed 7 1/2 percent of adjusted gross income.

the new employer does not offer insurance, or the worker becomes unemployed, the family must gamble with its health or buy its own coverage—without a tax break.

This is why so many of the 34 million Americans who are uninsured at some time during a year actually are workers—sometimes well-paid workers—or the dependents of workers. In fact, about 80 percent of uninsured Americans are workers or the dependents of working Americans.

Q. But is this problem really due to employment-based insurance?

A. Yes. This so-called portability problem does not occur with other major forms of insurance or major household expenditures. When a worker changes jobs he does not suddenly lose his life insurance and have to take a medical examination and apply at perhaps higher life insurance rates—or be turned down as a bad risk. He does not lose his car insurance. Nor does he have to refinance his mortgage. The reason is that these important items are portable because they have nothing to do with employment. And more important, the beneficial tax treatment of, say, life insurance or mortgage interest has nothing to do with employment. Only a family's health insurance availability and tax treatment depends on the bread winner's place of employment.

To understand the absurdity of today's tax treatment of health care, imagine a different America. In this America, the only way to receive a tax break on life insurance payouts or whole life insurance investments is to have insurance provided by an employer. And suppose, by contrast, a tax break is available for health plans whatever their source. The newspapers then would be full of heart-rending stories about families losing life insurance when they changed jobs, of widows left penniless when an older worker was laid off and could not afford a new policy because of a heart condition. But there would be no stories in such an America about workers losing health benefits when they changed jobs, because that would not affect health insurance.

Problem #2: If you work for a small firm, you are more likely to lack insurance.

Like other forms of insurance, the cost of health insurance generally is less when people are covered in a large group. Among the reasons: individual risks can be spread by the insurer across the group and so there is a smaller "risk premium" charged for a large group policy; paperwork costs associated with premium collections and marketing are smaller. This is why buying insurance through an organization (such as an automobile club or some other membership group) normally is cheaper. With employment-based health insurance, this means that the firm with 3,000 employees generally can get a much better rate than a firm with three employees. Worse still, the small firm can find its premium costs skyrocketing if it hires a fourth employee who has a large family or a checkered medical history. The reason: the cost of one high-risk employee cannot be spread widely.

The high cost of health insurance for small groups is why small employers are much less likely to provide health benefits and thus why so many uninsured Americans work for these firms. Some 43 percent of uninsured workers are employed by firms with 25 or fewer workers. It is also why all attempts to encourage wider employment-based insurance run into an enormous problem—how to make insurance affordable for small firms.

The fact that an individual works for a small firm, of course, does not affect the cost of his life insurance, his homeowner's insurance, or his auto insurance. This is because the premiums are not based on employment groups. To be sure, an employee of a small firm could join a large group to obtain the economies of scale and risk-spreading to reduce rates—perhaps a health insurance plan organized by a union, his church, the state farm bureau, or even an automobile club. This does not happen because there would be no tax relief for plans obtained through these non-employer groups.

Problem #3: If you are well-paid, you get a large tax break for health coverage. If you are low-paid, you get little or nothing.

The tax-free fringe benefit status of company-based plans is much like a normal tax deduction (except that there is also relief from Social Security taxes). This means that the higher the tax bracket of the employee, and the more generous the health plan, the larger the tax break. This "tax exclusion" was worth $66.6 billion in 1991 in federal taxes avoided, and another $8.3 billion in relief from state taxes.[4]

But according to Lewin/ICF, a Washington, D.C.-based econometrics firm specializing in health spending analysis, nearly 26 percent of this tax relief goes to households with incomes in excess of $75,000 per year, and just over 6 percent to households earning below $20,000. At the federal level, a household earning $100,000 or more has a tax break worth an average of $1,463 each year. A working family earning under $10,000 gets an average of $50 in tax help. If the family has no health plan (far more common for low-paid workers than high-paid workers), there is no tax break at all.[5]

What this means is that the revenue cost of the tax exclusion is heavily skewed towards upper-income earners. This in turn means the government gives little or no help to those working Americans who find it hardest to afford medical care. The system is great for Chrysler chief Lee Iacocca, but terrible for the part-time janitor at a local Chrysler dealership.

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4 The relief from federal income tax was $39.7 billion. The relief from Social Security (including Medicare) taxes was $26.9 billion.

5 Estimates prepared for The Heritage Foundation by Lewin/ICF, January 15, 1992.

Problem #4: The employer-based system encourages overinsurance, higher paperwork costs, and higher premiums.

The tax treatment of company-based insurance means that a $10 headache prescription or a $30 routine teeth cleaning covered by an insurance plan is tax-free while a $5 bottle of Tylenol or a $1 box of dental floss is not. Consequently, workers and unions press for even the most routine items to be included in health insurance plans. This means that company-provided health plans often "insure" workers and their families against completely predictable minor health costs. And every time a small cost is incurred, forms have to be filled out and processed, adding to the cost of the health plan. But this costly system of overinsurance is quite rational for the employee, even though it means high premium costs (which ultimately come out of his total compensation, of course) because it means these routine, minor costs are tax-free.

Workers would never insure themselves in this way for other aspects of their daily life, such as automobile care. Americans understand well that if they were to "insure" themselves against the cost of an oil change, new tires, tune ups, or even (to complete the analogy with routine health care) the cost of the weekly gasoline fill-up, the price of the extra insurance would far exceed the cost of paying for the items themselves. That is also the case for health insurance, according to a study by the Dallas-based National Center for Policy Analysis. Nevertheless, workers press their employers to overinsure them for health care because insurance is tax-free and because they live under the illusion that company benefits somehow are free.

Problem #5: It is extremely difficult for employers to hold down costs.

In any normal major retail purchase, say of a life insurance policy, or a car, or a house, there is a buyer and a seller. The buyer pays the seller and is the one who consumes the product or service. There may be expert intermediaries involved (a broker or a real estate agent, for instance), but they represent one of the sides in the transaction.

In employment-provided health insurance the buyer-seller relationship is very different because a third party (the employer) enters the picture. The employer is not the consumer of health services yet he buys the coverage and pays the hospital or doctor (directly, if the employer self-insures, or indirectly if the employer buys health insurance).

This third party arrangement leads to a very different relationship between the consumer (the patient) and the seller (the doctor or hospital) in health care transactions. For the patient, it means the cost of a service usually is of little or no concern, since the bill will be sent to the employer.

To be sure, as labor economists point out, the cost of company health coverage is part of the employee's total compensation package and thus ultimately comes out of the worker's pay, just as the "employer's share" of So-

cial Security taxes does. But the employee sees little or no direct relationship between the cost of a particular treatment and the size of his paycheck. Thus, there is little or no incentive to economize. Similarly there is no reason for the doctor to mention cost when suggesting a test or procedure to the patient.

To understand what this means for costs, imagine if companies "insured" their workers for the cost of buying and repairing the family car. Families would have little reason to bargain with a dealer — why would they accept a stripped-down car when they could have one loaded with options and "paid for" by their company? And car mechanics would do very well. A squeak under the hood? Why not have the repair shop take the engine apart? Or better still, why not put in a new engine? After all, the company is paying.

In company-based health insurance, then, the patient and doctor are concerned about benefits, but not costs. Meanwhile, the company is concerned about costs, but not benefits. This is a recipe for two things: rapidly rising costs and friction between employees who do not want to lose benefits and employers who want to cut costs. Employer health care costs are surging. They rose 21.6 percent in 1990 and 12.1 percent in 1991. The rate in 1991 was about four times the general rate of inflation. But as employers fiercely resist these efforts. According to the AFL-CIO, about three-fourths of strikes today center on health benefits.

THE REFORM OPTIONS

There are three principal ways to reform the health care system for working Americans (leaving aside reform of Medicaid, Medicare, and other health programs). Each of them places somebody in firm control of how many health care dollars are spent and who gets what services. Each has profound implications for the economy and the health care of American families.

Option One: This first plan is known as **"Play or Pay."** This actually would build on the current employer-based system while expanding Medicaid. In this system employers and the government would make the major decisions regarding what services Americans will receive and how much will be spent.

Option Two: The second plan recognizes that employer-based insurance is the heart of the problem. Known as the **"Single-payer"** or **"Canadian"** approach, this would substitute the government for employers, with the government paying for health care out of taxes and paying doctors and hospitals according to fees negotiated between providers and the only legal buyer—the government. The government also would set total spending levels for health care in America.

Option Three: The third plan, known as the **"Consumer Choice"** model, also recognizes the flaws of the employment-based system. But instead of letting the government take over, it would give consumers the ability to make the major decision in health care spending. It would do this by changing the tax treatment of health purchases to enable families to purchase their own plans.

HOW THE PLAY OR PAY APPROACH WOULD WORK

Under this approach, employers would be given a choice: provide at least a basic comprehensive health package for workers and their families or pay a payroll tax to fund coverage under a public program, similar to Medicaid. The main bill before Congress based on play or pay (S. 1227) is sponsored by Senate Majority Leader George Mitchell, the Maine Democrat.

This legislation would mean universal coverage. But it would have serious side effects. Among them:

Side Effect #1: Half of all working-age Americans would be dumped into a super-Medicaid program. When faced with a choice between providing a health plan and paying a tax, many employers would opt to end coverage and simply dump their workers into the public program. With the 7 percent payroll tax proposed as the basis for the Mitchell bill, the Washington, D.C.-based Urban Institute estimates that 51.7 million workers would lose their employer-sponsored coverage (one-third of workers who now have company plans).[6] This would mean 112 million Americans would be in a Medicaid-type program.

Side Effect #2: Americans would face huge tax hikes. If the public program were to be as large as reliable estimates suggest, high payroll or income taxes would be needed to support it. The Urban Institute estimates that with a 7 percent payroll tax, the public program would be underfunded to the tune of $36.4 billion per year. Even raising the payroll tax to 9 percent would only shave that shortfall to $25.2 billion. This would leave the government with three choices: 1) operate the system in the red, with the red ink adding tens of billions of dollars to the deficit; 2) raise taxes generally, slowing growth and cutting after-tax incomes; or 3) hike payroll taxes well beyond the level envisioned by the bill's sponsors. But any increase in payroll taxes is a tax on employment and means fewer jobs, especially for the lower-paid.

Side Effect #3: Insurance costs would soar. The cost of health coverage for employers would rise under the Mitchell bill. With a minimum benefits package in the Mitchell bill, the Urban Institute estimates that the extra cost to employers of providing insurance (or paying the tax) would rise by $29.7 billion, or 23 percent. For large firms, this means an average hike in health costs of 21 percent, and a 71 percent rise for firms with fewer than 25 employees. Moreover, if minimum benefits were mandated by Congress, unions would have the incentive to lobby Congress for across-the-board increases in basic benefits, rather than negotiating with individual firms.

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6 For an analysis of the Mitchell bill, see Edmund F. Haislmaier, "The Mitchell HealthAmerica Act: A Bait and Switch for American Workers," Heritage Foundation *Issue Bulletin* No. 170, January 17, 1992.

Similarly, medical groups would lobby for certain procedures to be included in the mandatory benefits package (as they have done successfully at the state level). These pressures could increase insurance costs dramatically, leading to more and more workers being shifted into the public program.

Side Effect #4: Small employers would face new hardships. The Mitchell bill does give small firms several years to comply with the play or pay requirement, and it includes various complex tax benefits to offset some of the high cost of small-group insurance and it would delay the mandate to play or pay for four years. But even these breaks add to the complexity of a supposedly simple approach and merely give a four-year breathing space.

Q. Is play or pay an example of "bait and switch"?

A. While purporting to be a simple extension of the current system, play or pay almost certainly would evolve into the government-run system publicly eschewed by its supporters. It baits and then switches.

Reason #1: Employers increasingly would have the incentive to pay rather than play, for the reasons indicated above.

Reason #2: The Mitchell legislation includes draconian anti-discrimination measures against any employer providing insurance who appears to use health condition as a reason not to hire or to lay off an individual (a natural response by employers if they are required by law to cover all families). Faced with the prospect of costly civil rights suits if they provide insurance, it is likely that more and more employers would choose the public option.

Reason #3: Play or pay proposals, including the Mitchell bill, set up all the apparatus needed to introduce a Canadian or British national health system. This includes boards to negotiate fees and set overall budgets—the central feature of the Canadian system. The legislation is replete with references to these boards being "advisory" or offering "recommendations" but few Washington insiders doubt that the board's decisions soon would be mandatory. Thus Americans might vote for comprehensive employer-provided benefits, but eventually they would find themselves in a super-Medicaid program.

Q. Will Congress suffer from the bait and switch?

A. **Absolutely not.** Once again, Congress exempts itself. The Mitchell bill would not apply to Congress, the executive and judicial branches, or federal workers.

The second approach reasons that private markets in health care simply do not work, and that in this one part of the economy the government can do a better job than the private sector. The model used is Canada. By using the government as the central buyer of health care, allocating resources, negotiating fees with physicians and hospitals and cutting out insurance middlemen, advocates of a Canadian-style system for America insist that overhead costs can be slashed, costs kept down, and quality improved. This best of all possible worlds turns out to be snake oil. Among the reasons:

Reason #1: Canada is very different from America.

While the Canadian system satisfies Canadians, it probably would not satisfy Americans or even work in the context of U.S. institutions. For instance:

☞ **The political culture is different.** Canadians, like Britons, put a premium on equality, and accept the long waiting lines that come with a system based on rationing (see below). Americans likely would not.

☞ **The political institutions are different.** Canada's parliamentary system, with its strong parties, is much less prone to special interest lobbying than the U.S. Congress. That makes it easier for the Canadian government to place strong constraints on doctors and hospitals—and patients. A Canadian system in America also likely would lead to the detailed micro-management by Congress that is seen in Medicare and the Veterans' health program.

Reason #2: There would have to be explicit rationing.

When the government sets an overall budget for health spending, but then declares that care is "free" to all citizens, heavy demand and limited supply lead inevitably to shortage and rationing. This is routine in Canada.

Q. Couldn't there be rationing in the U.S.?

A. No. Under the Canadian system, rationing takes two main forms. First, hospital and other budgets are set by government. And second, doctors routinely make rationing decisions every day—not to save a very premature baby, not to admit immediately a patient with mild chest pains, not to order a CAT scan on a crash victim with a headache. Doctors can do this in Canada because they do not work under the malpractice system facing American doctors. U.S. doctors would find themselves in court if they made rationing decisions like their Canadian counterparts. This means that the doctor-rationing process that is key to the Canadian system would be impossible in the U.S.

To make rationing work, two things would have to occur. First, Congress or the states would have to gut the medical liability laws—no easy political task in face of severe opposition from the trial lawyers and "public interest" groups. Or

second, Congress would have to legislate detailed priority lists for treatments and make no funds available for low-priority treatments—in effect, forcing doctors to ration. The political problem with this, as Oregon is discovering as it tries to introduce priority lists for Medicaid, is that Americans get very angry when treatment for *their* condition is at the bottom of the list. Trying to set national priority lists would be a nightmare for Congress, and would invite constant modification based on lobbying by patient groups and provider organizations.

Reason #3: The vaunted overhead savings of the Canadian system are highly suspect.

Supporters of the Canadian system say that billions of dollars could be cut out of the overhead in the U.S. system simply by replacing insurance companies with a government monopoly. The argument is that monopoly is efficient in health care, competition inefficient. To be sure, there are indeed great inefficiencies in the U.S. health insurance system, but these are due to perverse consumer incentives and not to deficiencies of competitive markets.

Supporters of the Canadian system tell only half the story. Any health system, like any business, can reduce overhead by eliminating procedures to make sure that resources are used wisely, staff are acting efficiently with an eye on cost, and inventory is kept at economical levels. It can institute budget limits so that the cash simply runs out when too many procedures are performed. But this does not lead to efficiency. On the contrary. In the U.S. health system an enormous amount of paperwork is devoted in health care, as in other parts of the economy, to make sure that health resources are used as efficiently as possible. This certainly generates paperwork but it promotes efficiency and reduces the cost to the economy of keeping patients away from work.

In Canada there are few if any such procedures to promote efficiency. Thus inefficiency is rife in the health system, with hospitals occasionally shutting down for want of key resources, long waiting lists for certain procedures, and outdated equipment in many hospitals. Moreover, when Canadians are waiting for treatment and unable to work, this imposes costs on the Canadian economy.

Reason #4: The Canadian system may be more expensive, not cheaper, than the U.S. system.

Supporters of the Canadian system point to the lower percentage of gross national product spent on health care as proof that the Canadian system is better at controlling costs. But various studies explode this myth.

- **Trend is the same.** If there were savings achieved in the Canadian system, they were made before the system became a national health plan in 1971. Ever since the mid-1970s, however, the rate of increase in costs in Canada has been virtually identical to that in the U.S.

- **Creative accounting cuts costs.** The Canadian system appears less costly because Canadia does not include many of the costs in its health spending data that the U.S. does. Example: the construction costs of hospitals are

not fully included in Canada's health care spending statistics, while in the U.S. they are. Example: the costs of treating doctors and other health workers are not fully included. If the Canadians employed the same accounting methodology as the U.S., says Jacques Krazny of the international accounting firm of Bogart, Delafield, Ferrier, Inc., based in New Jersey, Canadian health costs would rise by at least 1 percent of GNP.

☞ **Demographic differences.** The Canadian system is not treating the same kind of population. These lifestyle and demographic differences account for cost and quality differences. For example, the teenage pregnancy rate in the U.S. is two-and-a-half times that of Canada and U.S. drug use is higher. This leads to a higher proportion of low birthweight babies. The U.S. population also is older than Canada's. Such differences impose higher costs on the U.S. system, and also explain many of the apparent quality differences suggested by crude infant mortality rates and other national data. There is, moreover, a simple "bottom line" about quality in the U.S. and Canada. It is this: Canadians fly to U.S. when they want the best treatment. Americans do not fly to Canada.

Reason #5: A Canadian system in the U.S. would mean a rapid slide toward central planning.

One stark international lesson of price controls is that they become ever more complicated and pervasive. The Canadians have resorted to increasing regulation to combat the attempts of doctors and patients to "game" the system or avoid controls. To imagine how such a system would work in the U.S. it is unnecessary to go farther than Medicare, which is very similar in design to the Canadian system, with the government setting fees and regulating hospitals and doctors. Every year the regulations grow.

Reason #6: A government-run health system inevitably would be a two-tier system based on money and political connections.

Ordinary Canadians wait patiently in line to be treated. Those with money and political clout do not. When a businessman in Toronto is told his chest pains are not serious enough to warrant immediate treatment, he takes a plane to Buffalo, New York. Trips across the border to get faster and better treatment are routine for Canadians who can afford it. Politicians also do not wait. Either they go to the U.S. or they use their connections to jump the queue. Example: When Quebec Premier Robert Bourassa was diagnosed with skin cancer in 1990, he headed straight to the National Cancer Institute, near Washington, D.C. for treatment.

It is hard to imagine a U.S. senator, or a campaign supporter of the senator, waiting for a bed in a government-run system in the U.S. A bed would be found, as well as the best doctors; others would wait. Or the senator, like others with healthy incomes, would go to wherever he could get private treatment.

HOW A CONSUMER CHOICE SYSTEM WOULD WORK

Under a consumer choice approach, there would be changes in tax law and insurance regulations to empower the consumer to exercise greater control over the health care economy. Essentially, the aim would be to introduce the same market dynamics in health care—with consumers seeking the best value for money and providers competing for the consumer dollar—that work so efficiently in the rest of the economy.

One consumer-based system has been proposed by The Heritage Foundation, and is known as the Heritage Consumer Choice Health Plan.[7] This will be the subject of Part II of this series of *Talking Points*.

Another, very similar proposal has been advanced by the Washington D.C.-based American Enterprise Institute.[8] Still another by the Dallas-based National Center for Policy Analysis.[9] And while the recently announced health reform plan of the Bush Administration is less sweeping than these proposals, it contains some key elements of the consumer choice approach.

While these models do differ significantly in detail, they tend to include similar steps. These are:

Step #1: Consumers would have the same tax breaks whatever the source of their health plan, not just for employer-based plans.

By giving the same tax benefits to the purchase of health care insurance whether a plan is obtained by a family through an employer, a union, directly from an insurance company, or from any other source, consumers would be given the opportunity and incentive to "shop around" for the best value and not to overinsure. In addition, employees of small firms would have roughly the same choices as employees of large firms. Some proposals would set up a "health care IRA," or tax-free savings account, and a family could use this money to buy insurance or to pay for medical services.

Step #2: More assistance would go to those who need it most to obtain health care.

Unlike today's system, in which the biggest tax breaks go to those who have the biggest incomes and the most generous company-sponsored plans, the consumer choice plans would give most help to those who need it most. This generally is accomplished by introducing a refundable tax credit in place of the

7 See footnote 1.

8 Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff, "A Plan for 'Responsible National Health Insurance,'" *Health Affairs*, Volume 10, No. 1, Spring 1991.

9 *An Agenda for Solving America's Health Care Crisis* (Dallas, Texas: The National Center for Policy Analysis, 1991).

current tax exclusion for company plans. Tax credits do not favor upper-income families, and with a refundable credit the family receives a check from the Treasury if its tax credit exceeds its tax liability—so families too poor to pay much tax also are helped.

☑ Step #3: Regulations currently thwarting innovative health plans would be ended.

State mandates on insurance companies, federal and state insurance rules, and federal anti-trust regulations all make it difficult for new types of health plans to emerge to serve the consumer. Consumer choice plans thus include provisions to reduce this red tape, to increase competition among health care providers. Some include federal preemption of state laws, others would make it easier for plans to avoid these or federal rules.

Q. What would a consumer-based system mean for American families?

A. It would mean that families could shop around for the best combination of quality and price in health insurance, just as they do with other insurance purchases, and get the same tax relief wherever they obtained a plan. That would make health insurance like life insurance or mortgage payments, in that tax relief has nothing to do with the place of work.

It would also mean, just as with other forms of insurance, that the family would not lose its coverage just because the policyholder changed jobs or suffered a spell of unemployment. Thus it would solve the main problems faced by Americans families who move or lose their jobs.

Q. Wouldn't families have to become experts in health care?

A. No more than one has to become an engineering expert to buy a car, or an architect to buy a house. In major purchases of this kind, families consult experts to help them make choices, or they choose a product from a trusted organization or seller. The same would be true in health care. Typically families would not choose to bargain with individual doctors over the cost of services, any more than they bargain with auto component manufacturers and have a car built for them. Instead they would choose a comprehensive health plan.

Further, they would normally turn to a trusted plan sponsor or an expert to help them make a decision. A typical family might choose a plan sponsored by their union, or church, or they might simply ask their family doctor or insurance broker to recommend a plan.

Q. How would consumer-based systems control costs?

A. They would do so in the same way that consumer choice achieves cost control in every other major area of the economy: consumers sensitive to price seeking the best value for money.

Q. Is there any evidence that such a plan works?

A. Yes. Large corporations with "cafeteria" plans that include a range of health care options for their employees have seen their costs rise less rapidly. Even more striking, the Federal Employee Health Benefits Program (FEHBP), which covers nearly 10 million federal workers and their families, as well as retirees, gives civil servants a wide range of plans and the financial incentive to choose the best value for money. The result: Over the last decade the rise in costs in the FEHBP has averaged about two percentage points less than in the private sector. During the last three years, the premium increases have averaged about half that of the private sector.[10]

CONCLUSION

The debate over health care is one of the most important domestic policy discussions since Congress debated the creation of the Social Security system in the 1930s. The decisions that Congress makes will involve close to one trillion dollars a year in current spending. The pocketbooks of every American will be affected, as will their health.

Reform of the health care system thus must not be the product of election-year posturing and rhetoric. It must be based instead on careful attention to the facts, and there must be reasoned discussion of the causes of today's problems and the merits of rival reform options. If Congress debates health care reform in this way, it will be possible for the U.S. to create a comprehensive health care system that becomes the envy of the world.

10 Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.