THE HERITAGE LECTURES

392

How the Maryland Health Plan is a Model for the Nation

By Carl J. Sardegna

The Heritage Foundation

Founded in 1973, The Heritage Foundation is a research and educational institute—a think tank—whose mission is to formulate and promote conservative public policies based on the principles of free enterprise, limited government, individual freedom, traditional American values, and a strong national defense.

Heritage's staff pursues this mission by performing timely and accurate research addressing key policy issues and effectively marketing these findings to its primary audiences: members of Congress, key congressional staff members, policy makers in the executive branch, the nation's news media, and the academic and policy communities. Heritage's products include publications, articles, lectures, conferences, and meetings.

Governed by an independent Board of Trustees, The Heritage Foundation is a non-partisan, tax exempt institution. Heritage relies on the private financial support of the general public—individuals, foundations, and corporations—for its income, and accepts no government funds and performs no contract work. Heritage is one of the nation's largest public policy research organizations. More than 200,000 contributors make it the most broadly supported in America.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

The Heritage Foundation
214 Massachusetts Avenue, N.E.
Washington, D.C. 20002-4999
202/546-4400
http://www.heritage.org

How the Maryland Health Plan is a Model for the Nation

By Carl J. Sardegna

As this audience knows only too well, growing concerns about health care costs and poor access have stimulated the development of multiple health care reform proposals. Proposals from members of the House and Senate, medical specialty societies, public interest groups, and organizations such as The Heritage Foundation, to name a few sources, are piling up on the public policy table at a rapid clip.

Yet when all of these proposals are distilled, three models stand out:

- **"Single-payer,"** in which the government runs the health care system in one way or another;
- **"Play-or-pay,"** which mandates employer financial contributions to expand access; and
- **"Consumer choice,"** which involves the use of tax credits or vouchers to give consumers a direct financial incentive to behave as responsible buyers of health care—or in other words, to put market incentives into the health care system.

I support the version of the Consumer Choice approach which is being actively considered in Maryland as a statewide demonstration. I believe it can work in Maryland, and I believe it offers a model for the nation as well, because unlike the other approaches, it achieves four critical health care reform goals:

First, it provides universal and continuous access for all to standard insurance benefits without regard to employment or health status;

Second, it moderates costs by using competition to pressure insurers and health care providers to operate efficiently, and to put more purchasing power in the hands of consumers;

Third, it is budget neutral and uses an equitable financing methodology; and

Fourth, it preserves what is good about our system —a system that fosters competition and innovation, encourages the development of technology, and allows Americans to keep what they value so highly, the right to choose doctors they trust, without long waits for care.

All four goals must be achieved if we are to see true reform in this country. The piecemeal solutions of the past simply have not worked. In fact, they have exacerbated our problems.

I contend that neither the single-payer nor the play-or-pay approach offers viable solutions for fundamental reform. The single-payer model forces cost control through global budgeting by price regulation and capping the volume of services. As in every other country where this has been tried, the inevitable result is rationing and waiting lines.

Carl J. Sardegna is Chairman and CEO of Blue Cross and Blue Shield of Maryland, Inc.

He spoke at The Heritage Foundation on May 27, 1992.

ISSN 0272-1155.

I also believe that this model will discourage innovation in the development of new medicines and technologies. Furthermore, consumer research repeatedly shows that while most Americans want reform, they do not want a system run by the government.

The play-or-pay approach leaves one-third of the uninsured population uncovered, including many unemployed and part-time workers. This model also puts an enormous financial burden on employers, without offering them any hope of reducing their health care benefit expenses and becoming more competitive.

Finally, both approaches would require a substantial infusion of funds into a system that already costs too much, at a time when the country is staggering under the weight of our deficit. Neither approach would encourage competition or put market forces to work to moderate cost increases.

It probably goes without saying, that one of the reasons that health care costs are consistently higher than the Consumer Price Index is that the end users of the health care services, consumers, and those who order health care services, health care providers, have been shielded from the economic consequences of their choices by insurance.

Imagine what would happen if everyone in this country, for the price of an annual premium, had a food card that provided access to any grocery store and covered costs, with a deductible or co-payment, of whatever food products the store manager recommended. The lack of marketplace incentives surely would result in a steady escalation of food prices.

Ten Points. Simply put, we need marketplace incentives in the health care system that put the consumer in the driver's seat. The Consumer Choice Health Plan being debated in Maryland does that. In this model:

1) All Marylanders, including those currently served by Medicaid, and excluding only those already covered by Medicare, would purchase a comprehensive standard insurance program from a qualified carrier. Purchase of supplemental insurance would be optional.

2) Consumers would purchase the standard insurance from their employers or shop on the open market. Those who are unemployed could obtain insurance from designated public agencies or brokers.

3) The standard insurance would be similar to comprehensive programs available on the market today and would include preventive as well as acute care benefits.

4) Issuance of the standard insurance would be guaranteed and renewable without regard to health status or claims experience. In other words, no more exclusions on pre-existing conditions, and no more loss of insurance when you change jobs.

5) All Marylanders, not just those at lower income levels, would receive a refundable tax credit or voucher to use toward the purchase of the standard insurance.

6) The tax credit would be progressive and the amount would be geared to pay 100 percent of the estimated cost of the standard plan for those below the poverty level, and scaled down to where it would provide 50 percent of the cost of the standard plan for families with incomes over $100,000 (See Table 1).

7) The tax deduction for health care benefits received by individuals would be eliminated. Today, high income individuals benefit from a hidden tax subsidy because

they do not pay taxes on the value of health care benefits paid by their employers. The value of this subsidy is $65 billion nationally and $1 billion in Maryland.

It is important to note that in the Maryland Plan, the value of the progressive tax credit is calculated to offset taxes in a way that families earning less than $50,000 will break even or gain financially from this proposal, assuming the employer does not contribute anything to the Plan. If the employer holds the employee harmless, which I believe most will do, even those earning $100,000 or more will break even (See Tables 2 and 3).

8) Consumer protection would be built in. In order to do business in the state, carriers would have to be qualified. To be qualified they would have to offer the standard insurance, meet certain financial criteria including caps on administrative expenses, and be proficient in managing the cost and quality of care.

9) The workplace would remain the focus for purchasing health care benefits for most consumers. All employers would offer a standard and a supplemental insurance program to their employees, but financial contribution to the plan would be optional, just as it is today.

10) Employers would all pay a 4 percent payroll tax as their only mandatory contribution to health care benefits. This is significantly less than the 8 percent to 10 percent of payroll they are paying today. For those employers who are not contributing today, it would provide an affordable way for them to participate.

Let's look at how this would work in an employment setting. First, an employer would arrange through a qualified carrier or broker to offer a standard and supplemental plan at group rates to its employees, and decide the level of its financial contribution. We estimate that employer savings will be between $500 and $1,000 per employee, depending on the level of health care benefits currently provided (See Table 4).

An employer who wanted to maintain the same benefits program that was in place before consumer choice would already be financially ahead of the game, because the cost to the employer to fund the identical program will be reduced by the amount of employee tax credits now available to defray the cost.

Employer savings could be passed on to employees as increased wages, invested, or retained as earnings or profit.

Employees, knowing the value of their tax credit and how much the employer would pay (in other words, how much they have to spend), would decide whether to purchase the standard benefit from the employer or search for a better deal on the open market, as well as whether to purchase any supplemental benefits.

Value-Conscious Consumers. Comparison shopping would be greatly simplified because the standard insurance benefit would be just that—standard. When consumers know how much money they have to spend and can truly comparison shop, they will be far more value-conscious. Insurers will be forced to offer insurance products at or below the target price associated with the full value of the tax credit to stay in business. (Just as an aside, I can tell you from our experience at Blue Cross and Blue Shield with consumers who purchase insurance directly, that they are very value-conscious and they put enormous pressure on us to deliver good insurance values.)

Under the competitive pressure generated by the Consumer Choice Health Plan, qualified carriers will in turn contract with health care providers in organized delivery systems that can demonstrate the ability to deliver quality care in an efficient and cost-conscious manner. This is

managed care in action. Obviously, selective provider contracting is happening today, but it will intensify and become much more sophisticated.

Consumer demand for value also will put enormous pressure on the entire system—health care providers and insurers alike—to find ways to eliminate waste in the system. The Consumer Choice Health Plan also assumes the adoption of a uniform bill and installation of electronic networks throughout the state to eliminate the cost and burden of today's paperbound processes. The Plan also assumes that there will be caps on administrative expenditures.

Sources of Funds. One of the cornerstones of the Consumer Choice Health Plan is its funding mechanism. There is enough money in the system today to expand basic insurance to all and to fund the tax credit. The funds just haven't been allocated equitably. The five principal sources of funds are as follows:

- Individual income taxes associated with the elimination of the tax exclusion for health care benefits as well as the deduction for out-of-pocket medical expenses.
- A 4 percent employer payroll tax. As I said before, employers who contribute to health care benefits today pay between 8 percent and 10 percent of the payroll.
- Increased corporate tax revenues on any increased profits earned to the extent that employee tax credits reduce the level of employer expenses for health care benefits.
- Federal and state public funds currently spent for the acute care part of Medicaid and other public health programs.
- Uncompensated care dollars no longer needed to cover hospital bad debt.

It all adds up to a program which is budget neutral (See Table 5). It can be done. The math works for Maryland and it works for the nation.

Can the Consumer Choice Health Plan be successful? Yes, I believe it can. The current Federal Employees Health Benefits Program is structured somewhat like the Consumer Choice Health Plan, in that it offers a specified amount of financial contribution which is known to federal employees together with wide choice of plans.

I believe that the success of the FEHBP program in moderating costs can be attributed in large part to the design which gives consumers a clear role in making their purchase decisions.

As you can see, this proposal varies in significant ways from that proposed by President Bush and somewhat from that proposed by The Heritage Foundation. The Bush proposal provides a tax credit for individuals at the lower income scale, but offers no explicit funding mechanism. It also continues the tax deduction for employer-based insurance, which insulates consumers from the market.

Employer Participation. The Heritage proposal goes much further, by repealing the tax deduction for health care benefits, and imposing an individual mandate, as well as expanding the tax credit to a wider income band. However, the Maryland Plan relies much more heavily on employers to participate through the requirement that all employers offer insurance as well as help finance the tax credit through the 4 percent payroll tax.

In conclusion, I believe that the strength of the Maryland Consumer Choice Health Plan is that it achieves all four reform goals in an integrated way. It provides universal access to a standard benefit which eliminates the need for a separate public program for acute care Medicaid.

The Consumer Health Plan brings competitive pressures into the system to control costs. It reallocates funding equitably so that it is budget neutral. And it preserves what is good about our system.

Solid and Equitable. Obviously there are aspects of this proposal that are controversial and details that are subject to further discussion. But I believe that the principles inherent in the Plan are solid and equitable. The truth is that fundamental reform requires everyone to give a little to make it work.

If the problems of the system are looked at from an integrated rather than a piecemeal perspective, I think we will have a real shot at success.

At this point, Delegate Casper Taylor and others are working hard in Maryland to implement the Consumer Choice Health Plan as a statewide demonstration. We strongly believe that experimentation at the statewide level is the way to go because of the dramatic changes that potentially could occur with a significant part of the national economy under a permanent change of such scope.

It is important to note that when other countries moved to a form of national health system, health care spending was approximately 3 percent to 4 percent of the GNP. Ours is now in excess of 12 percent. We cannot afford to make errors that would dramatically affect our economy in a negative way.

Let me end by quoting Franklin Delano Roosevelt, who said: "The test of our progress is not whether we add more to the abundance of those who have too much; it is whether we provide enough for those who have too little." Consumer Choice does just that in the health care arena.

♦♦♦

Table 1
Progressive Tax Credit

Family Income	Tax Credit	% of Premium
$0 - $13,359[1]	$3,400	100
$13,360 - $26,718	$3,060	90
$26,719 - $49,999	$2,890	85
$50,000 - $99,999	$2,210	65
$100,000 and above	$1,700	50

[1] Poverty level for family of four.
Source: Center for Health Policy Studies, Columbia, Maryland

Table 2
Financial Impact of CCHP on a Representative Employee
(Salary $45,000; Family Coverage)

	Consumer Choice	
	No Employer Contribution	With Employer Contribution to Hold Employee Harmless
Total Average Cost[1]	$3,400	$3,400
Tax Credit — (85 percent)	$2,890	$2,890
Contribution to Health Coverage		
Employer	—	$510
Employee	$510	—
Federal and State Tax Liability[2]	$662	$779
Net Cost to Employee[3]	$1,172	$779
Current Cost to Employee[4]	$1,200	$1,200
Savings to Employee[5]	$28	$421

Source: Center for Health Policy Studies, Columbia, Maryland
[1] Estimated average cost of standard managed care benefits package.
(Assumes cost of standard benefits package is reduced 15 percent through managed care and benefit design.)
[2] Marginal tax rate of 22.9 percent on value of tax credit plus employer contribution.
[3] Total of employee contribution and tax credit.
4 Average employee contribution to current health care premium.
5 Difference between current cost and net cost.

Table 3
Financial Impact of Consumer Choice Health Program on Representative Families

Family Income	Net Cost Impact	
	No Employer Contribution	With Employer Contribution
$12,000	$1,200	$1,200
$25,000	$422	$713
$45,000	$28	$421
$75,000	($675)	$156
$100,000	($1,100)	($12)

Source: Center for Health Policy Studies, Columbia, Maryland

Table 4
Financial Impact of CCHP on a Representative Employer (50 Employees: $1,350,000 Payroll)

	Current	Consumer Choice	
		With Employer Contribution	No Employer Contribution
Employer Premium Contribution	$140,000[1]	$25,500[2]	N/A
Reduction in Premium Contribution (or "Gain")	0	$114,500	$140,000
Maximum Corporate Tax on "Gain"[3]	0	$31,144	$38,080
Payroll Tax of 4 Percent	N/A	$54,000	$54,000
Net Cost to Employer	$140,000	$110,644	$92,080
Net Savings to Employer	0	$29,356	$47,920

Source: Center for Health Policy Studies, Columbia, Maryland
[1] 10.4 percent of payroll ($2,800 per employee).
[2] 1.9 percent of payroll.
[3] 34 percent of gain in revenue to employers.

Table 5
Consumer Choice Health Program
Funding of Tax Credit in Maryland
(millions)

Tax Credit Cost	**$4,740**
Increased Individual Tax Revenue[1]	$1,043
Payroll Tax of 4.0 Percent	$2,600
Increased Employer Tax Revenue[2]	$472
Reallocated Federal/State Medicaid Dollars[3]	$345
Reallocated Hospital Uncompensated Care Dollars and Other Revenue Sources	$280
Total Funding Sources	**$4,740**
State Budget Impact	**0.0**

Source: Center for Health Policy Studies, Columbia, Maryland
[1] @ 22 percent rate (Federal and State combined)
[2] @ 34 percent Rate of 80 percent of "gains" (Resulting from reduced premium cost)
[3] Based on 1990 Medicaid data.