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THE MITCHELL HEALTHAMERICA ACT: A BAIT AND SWITCH FOR AMERICAN WORKERS

INTRODUCTION

Among the most prominent in an array of health care reform measures now pending in Congress is S. 1227, the "HealthAmerica: Affordable Health Care for All Americans Act." The bill's prominence derives mainly from its sponsorship by George Mitchell, the Maine Democrat who is Senate Majority Leader.

The 349-page bill also is the most recent and comprehensive version of what is called the "play or pay" approach to health care reform. In this, the federal government would require employers either to "play" by covering their employees (and employee dependents) with at least a specified minimum level of health insurance or to "pay" a payroll tax to fund an expanded Medicaid-type program to cover their workers and dependents. The only employer exempt from this system would be the federal government. Buried in the bill is a provision that congressmen and their staffs, like other federal workers and retirees, would continue to enjoy a wide choice of private health plans.[1] The payroll tax would be set as a percentage of total wages paid to employees. The new government program created by S.1227 would be called "Americare." Co-sponsors of Mitchell's bill include Senators Edward Kennedy of Massachusetts and Jay Rockefeller of West Virginia, both Democrats.

High Costs, Adverse Incentives. While S. 1227 is a sincere attempt by Mitchell and others to address the problems of America's health care system, the sponsors apparently have not calculated the high costs and adverse incentives their bill would create for employers, consumers, health care providers, taxpayers, and government officials. According to an Urban Institute study released last week, the Mitchell plan would cost employers nearly $30 billion per year more in

1 See Title II, Section 2713(3)(ii) of the bill.

insurance costs than they pay today, and would cost $36 billion more in taxes than the legislation estimates for the public program to break even. Over 50 million Americans would be shifted from company-provided health plans into the expanded Medicaid-type public program, including over one-third of all currently insured workers.[2]

Among the specific shortcomings of the bill:

♦ ♦ A large number of employers could cut their cost of providing health benefits and avoid the red tape associated with company-based health plans simply by dropping their current private health insurance and paying the tax to enroll their workers in Americare. Consequently, many middle class Americans would lose their current generous coverage and be forced into an expanded Medicaid-type program, consigning them to a "one size fits all" level of coverage and quality of care. The Urban Institute estimates that 51.7 million Americans would lose their employer-provided insurance in this way. Over one-third of workers now covered by company plans would be forced into the public program. This is, moreover, almost surely an underestimate. Since employers that continued to offer insurance could be fined heavily by the federal government or sued by prospective employees if there were claims that the employer deliberately was not hiring individuals with family medical problems, many firms would opt to pay the tax to avoid the threat of litigation.

♦ ♦ The new employer tax payments and premium payments by families would fall far short of covering the actual expenses of the new program, leaving large deficits to be financed by taxpayers. The Urban Institute estimates that the plan's costs would outstrip income by $36.4 billion annually. This means that payroll or other taxes would have to rise, destroying jobs, or that benefits in Americare would have to be cut.

♦ ♦ The employer mandate provisions would do nothing to control escalating health care costs. Mitchell apparently realizes this because his bill would create a massive, non-market, central planning bureaucracy to limit expenditures, control prices, and restrict capital investment for the entire U.S. health care system, including the privately insured sector. This is effectively the same structure used in the nationalized medical systems of Britain, Canada, and other countries that ration and deny medical treatments to cut costs. Mitchell's proposed central planning structure would create a shortage of medical services in the face of growing demand, and would limit or delay the adoption of new health technologies. Health care providers under such a system would have no incentive to improve or even maintain quality, or to innovate and develop new medical advances. Instead, providers of health care would have an incentive to do only the minimum required.

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2 Sheila Zedlewski, Gregory Acs, Laura Wheaton and Colin Winterbottom, *Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs* (unpublished paper for the U.S. Department of Labor, Washington, D.C.: The Urban Institute, January 8, 1992).

The play or pay approach enshrined in the Mitchell bill would give the average currently insured worker and family a lower standard and quality of care, in a system of gradually deteriorating facilities and increasingly outmoded technology. Significantly, lawmakers have made sure that they would not be in the system they want to create. The Mitchell bill exempts Capitol Hill staffers and other federal workers and retirees from the health system that would apply to all other Americans.

Even those Americans who are uninsured today most likely would be worse off under the bill, though its primary purpose is to help them. Many would lose their jobs as employers cut payrolls in response to the high costs of expanded coverage mandated by the government. Many other workers would see their paychecks shrink as employers offset the new tax or insurance costs by cutting workers' cash wages. Past experience makes such responses by employers a near certainty.

No Compromise. The Mitchell bill is a poorly aimed reform effort. The proposal in no sense is a compromise, as its sponsors claim, between the current American system and government-run national health care. Rather, the system created by the Mitchell bill quickly would collapse into a full-scale, government-run system, with continuous budget problems and lower-quality care for most Americans. In short, the Mitchell bill is a classic example of bait and switch.

To be sure, America's health care system has serious flaws. But instead of trying to force employers to operate or pay for a national health care system, what is needed are reforms to establish a consumer-choice health care system in which the tax treatment of health spending is changed to permit families to choose their own health plan and in which government assistance to buy health care is targeted to the needy. Such a consumer-choice system would create powerful market incentives to control costs while increasing incentives on physicians and hospitals to deliver the highest quality medical care in the world.

HOW PLAY OR PAY IS SUPPOSED TO WORK

The Mitchell play or pay bill would require all employers either to purchase specified private health coverage for each of their employees and their families or to pay a new payroll tax to fund an expanded Medicaid program, renamed Americare, that would give such coverage. The federal government and its employees would be exempt from these requirements. Federal workers are covered by a system known as the Federal Employee Health Benefits Program, which allows them to choose between dozens of private health plans.

If employers chose to "play" by insuring their workers, the coverage they would be required to give includes specified services and sets limits on how much workers can be charged for the cost of their health insurance and medical care. In addition, new obligations and restrictions would be imposed on employers and insurance companies, including their hiring practices.

Among the Mitchell bill's key provisions:

1) Required Coverage.

Insurance plans provided by employers would have to contain unlimited coverage for inpatient and outpatient hospital care; inpatient and outpatient physician services, including dentist, optometrist, podiatrist, and chiropractor services; and diagnostic tests. Plans would have to cover prenatal and well-baby care, as well as preventive services—defined to include well-child care, pap smears, and mammograms. The plans would need to pay for at least 45 days per year of hospitalization treatment for mental disorders and for at least twenty visits per year for outpatient psychotherapy and counseling. States would not be permitted under the bill to raise the minimum level of coverage offered by employers above the level established by these federal mandates.

2) Cost-Sharing Limits.

Health insurance plans would not be allowed to impose annual deductibles on employees of more than $250 or one percent of their wages, whichever is greater, for individual coverage or $500 (or two percent of wages) for family coverage. This maximum deductible would be increased each year at the rate at which the Consumer Price Index rises. The payment for required services, which is the percentage of each charge that would be paid directly by the patient, in general could be no greater than 20 percent of that charge, except for mental health care where a co-payment of up to 50 percent would be allowed. The plans would have to include an annual limit on the total of deductible and co-payment fees payable by an employee. This would have to be no more than $3,000 (indexed each year to consumer prices) or 10 percent of the employee's wages, whichever is greater.

3) Premiums.

Full-time employees, defined as those working 25 hours per week or more, could be required to pay up to 20 percent of the premiums for the mandated coverage under company-provided plans. Part-time employees, defined as those working less than 17.5 hours per week, could be required to pay up to 50 percent of the insurance premiums. Employees working between 17.5 and 25 hours per week, defined as less than full-time workers, could be required to pay between 20 percent and 50 percent of premiums on a sliding scale, depending on the average hours worked per week.

4) Insurer Regulations.

The mandated coverage could be provided through traditional insurance, a managed care program, such as a Health Maintenance Organization (HMO), or a Preferred Provider Organization (PPO). Individuals covered by an HMO or PPO normally pay a fixed monthly charge and are not billed for care from physicians or hospitals in the plan, although they can be charged all or part of the bill if they receive treatment from a provider not approved by the plan. Insurers would be prohibited from excluding or limiting coverage for any individual on the basis of

a pre-existing medical condition. This means that if an individual has been treated, say, for cancer in the past few months, or suffered from a chronic complaint such as diabetes, the insurer could not deny or limit coverage.

5) Anti-Discrimination.

Employers would be prohibited from discriminating in their hiring against workers because the workers are in poor health or have family members in poor health. For any failure to comply with this nondiscrimination requirement, the employer would be liable for all damages to the employee (that is, the cost of his or her treatment) and for a civil penalty of up to 15 percent of the employer's total wage payments for all employees for the year.

HOW THE AMERICARE PROGRAM WOULD WORK

The Mitchell bill would require those employers who choose not to provide the specified minimum private insurance described above to pay a new payroll tax. This tax revenue would go into the Americare program, which would give health insurance coverage to the employer's employees. The tax rate on employers who choose to "pay," not "play" is set in the bill as a percentage of wages. The percentage would be based on the cost of financing the Americare program. Sponsors estimate that the initial tax rate would have to be set at about 7 percent of wages.

Workers covered by Americare, in general, would pay 20 percent of the cost of their coverage. All workers with family income below the poverty threshold (about $14,000 for a family of four), however, would be exempt from paying premiums. The premium paid by families above the poverty threshold would rise according to income up to 20 percent of coverage costs for workers with family incomes between 100 percent and 200 percent of the poverty threshold. In no case, however, would these workers have to pay more than 3 percent of family income in annual premiums. Part-time workers would pay no more than 10 percent of the cost of their coverage.

Americare Benefits. Americare would supply virtually the same benefits as would be required for the private insurance, with the same deductible and co-payment provisions.[3] Workers and their dependents with family incomes below the poverty threshold would be exempt from the deductible and co-payment charges, with the full deductible and co-payment fees phased in gradually for those with family incomes between 110 percent and 200 percent of poverty.

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3 The one difference is that Americare would provide children under 21 with "early and periodic screening, diagnosis and treatment," which includes regular physical check-ups and eye, dental, and hearing examinations, and any treatment that is found necessary as a result of such check-ups and examinations that may not otherwise be covered under the program. Families with private coverage could purchase such additional benefits from their private insurer, or could purchase such coverage from Americare by paying a premium to be set to cover the cost of those services.

Workers and their dependents with family incomes below the poverty threshold, or those who otherwise qualify for Medicaid, would receive through Americare any additional benefits included in the Medicaid plan of the state in which the family resides, except for care in a mental hospital, nursing facility, or hospice, or home health care. A state could add benefits to Americare for its residents, but would have to finance these benefits entirely out of state revenues.

Provider Reimbursement. The Medicare program for the elderly includes a schedule of fees for doctors and hospitals treating Medicare beneficiaries. These payment rates and reimbursement policies would apply to the services provided under Americare. This means Americare would pay physicians according to the controversial new relative value scale (RVS) system currently being introduced into Medicare.[4] A state could choose to use its existing Medicaid payment rates and policies for the first six years after the legislation takes effect, but it would have to adopt the Medicare payment system by the seventh year.

Americare, therefore, would expand Medicaid dramatically, making it available to all working-age families, paying the full medical costs for all workers and dependents below the poverty line and charging a sliding-scale premium for other workers. Besides the taxes and premiums paid into Americare by employers and workers without private coverage, the program's remaining expenses would be financed jointly by the federal and state governments according to the existing Medicaid formula.

Financing. Since the bill would not require the program's taxes and premiums to be sufficient to finance Americare coverage, even for workers who are not poor, the program's budget will dip deeply into federal and state general revenues. Last week's Urban Institute study estimates that Americare will cost $64 billion more each year than the revenue from its premiums and payroll tax, assuming a 7 percent tax. Current public programs for the non-institutionalized non-elderly cost $28 billion, leaving a shortfall of $36.4 billion to be raised from Americans through additional new taxes.

SPECIAL SMALL BUSINESS PROVISIONS

The sponsors of S. 1227 realize that their bill's mandates would impose a heavy burden on small businesses, which find it difficult to afford health insurance. They would be hard hit by a hike in payroll taxes. Included in the legislation therefore are special provisions for small businesses designed to ease those burdens.

4 See Robert E. Moffit, Ph.D., "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Heritage Foundation *Backgrounder* No. 855, September 23, 1991.

First, the requirement to purchase the specified private insurance or pay new payroll taxes into Americare would not apply to firms with 25 to 100 workers until four years after passage of the act.

Second, such employers would continue to be exempt if the number of uninsured workers employed by them declined by 75 percent within the first four years. For firms with fewer than 25 workers, the initial exemption period would last five years.

Third, a complex and restricted tax credit would be allowed for the health insurance expenses of very small employers. This credit could be applied against the firm's taxes and would be equal to 25 percent of annual insurance expenses up to $3,000 for each employee paid $15,000 per year or less. The credit would be phased out for workers making between $15,000 and $20,000 per year and would not be available to offset the cost of insurance for workers earning above $20,000. These phase-out levels would be indexed to increases in average wages over time. The credit would apply to firms with 40 or fewer workers, and phased out proportionally for firms with up to 60 workers. Even more confusing, the credit would be reduced proportionally to the extent that the employer's profits exceeded its annual health insurance costs, with the credit phased out completely when profits equaled three times such costs.[5]

The bill also would allow self-employed workers to deduct from their personal income tax the full cost of health insurance meeting the minimum requirements.[6]

Cost Control Regulations. In an attempt to constrain America's rapidly rising health costs, the bill would establish a Federal Health Expenditure Board. The eleven members of the Board would be appointed by the President, with the Senate's approval, and represent the public as well as health care providers and corporate purchasers of health care. This Board would set goals or target limits for the total amount of health care spending in the United States each year. The Board would set separate targets for spending on hospital services, physician services, laboratory services, pharmaceutical products, and other health services, as well as separate limits for health spending in each state. The Board also would set similar goals for the quality and availability of health care.

The Board would arbitrate between representatives of health care providers and purchasers. The aim would be for the Board to negotiate the terms and conditions of health care payments and delivery throughout America. It could seek, for example, to establish uniform payment rates for medical services, minimum standards for the quantity and availability of services, and a national plan for capital investments in new technologies and facilities.

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5 Eligible employers could take this tax credit in addition to the regular deduction for employee wages and benefits (including health insurance) from corporate taxable income.

6 The bill also includes several provisions seeking to expand access to the private insurance market for small employers, such as requiring guaranteed issue and guaranteed renewability of policies to all small employers on the same terms as for others, regardless of the health status of the employer's workers. These provisions should be rejected on their own merits apart from the rest of the bill.

According to the Mitchell bill, the Board's negotiations would aim at assuring that its expenditure goals are met. Meetings of representatives from each major health care sector (such as hospital services and physician services) would be convened in each geographic area. These representatives, who would bargain on behalf of the consumer and provider interest groups, would be chosen by special petitions or elections or would be selected by the Board.

Based on Medicare. The payment system negotiated in detail in this way would be based on the Medicare payment system. If a majority of the negotiators for each side agreed on payment rates that the Board determined would achieve its predetermined expenditure targets or other goals, it would issue regulations enforcing the agreement. Those regulations would be legally binding on the providers and purchasers represented by the negotiators. If the negotiators failed to reach an agreement satisfactory to the Board, it could issue advisory regulations suggesting, but not mandating, maximum payment rates or other restrictions.

The Board also would establish a system of uniform billing by physicians and hospitals, as well as a uniform system of supplying information to purchasers. In addition, the Board would develop and introduce a system to measure the effectiveness of health care services.

Each state would be required to establish a consortium of all but the largest insurers in the state, to handle claims processing and payment for these insurers. The objective is to cut the supposedly high overhead costs associated with a large number of small competing insurers. Health care providers, large insurers, and corporate purchasers of health services also could join the consortium, and the federal Board could allow the consortium to conduct negotiations for the terms and conditions of health care within the state. To do so, these consortia would be given an explicit exemption from the antitrust laws.

A Quality Improvement Board would be established in each state to adopt guidelines for appropriate medical practices, recommend quality improvement, and develop measures of health care performance and outcomes. The Board then would certify certain health care providers in the state as outstanding providers based on their compliance with the Board's guidelines and recommendations. Insurers would be prohibited from denying payment for any services performed or ordered by a certified outstanding provider unless the service in question is not covered by the policy.

MEDICAID FOR THE MIDDLE CLASS

The proponents of the play or pay approach at one time argued that it had the virtue of simplicity. It would simply extend the current employer-based system while giving employers a straightforward choice—provide coverage or pay a tax so that the government could provide coverage. But as the 349-page Mitchell bill indicates, setting up such a system is far from simple. Worse, the legislation would not work as advertised.

Among the problems with Mitchell's pay or play:

Millions of Americans would be dumped into the public program.

S. 1227 purports to allow a choice between private insurance and the public Americare program. In reality, however, it would lead to millions of workers being dumped into the public Americare program, including those who now have employer-provided insurance. This is because the proposed legislation would give most employers the incentive to pay the new Americare payroll tax and drop the private insurance they now give their workers.

It is not hard to understand why dumping would be widespread. The current national average cost of employer-sponsored health insurance for workers with family coverage is about $300 per month, or $3,600 per year. The minimum health insurance package mandated by S. 1277 is more generous than typical company-provided plans, and so would cost at least as much as the current cost of an average plan. The 7 percent payroll tax rate for Americare would cost the employers less than the insurance premiums now do for employees earning less than $51,000 per year.[7] The average taxable wage in the U.S. work force is now about $25,000 per year.[8] Thus, the great majority of companies have average per employee payrolls of less than $51,000 per year and would save money by dropping their current private coverage, dumping their workers into Americare, and paying the payroll tax instead.

If the Americare tax were set at a high enough level to cover true costs, and if Americare coverage were to be comparable to average plans in the private sector, the cost of Americare for employers with workers making the average wage would be roughly the same as the cost for private insurance. Since Americare is financed by the same percentage tax rate applied to all covered payrolls, however, the tax cost of Americare would decline proportionally for employers with workers earning below average wages, while the cost of mandated private insurance would be at about the same level. As a result, there would be a greater incentive for firms employing lower-paid workers to shift them into the public plan —while the payroll tax revenue to finance their coverage would tend to be well below the actual cost of services.

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7 For an employer with an average per employee payroll of $51,000 per year, the cost of Americare would be 7 percent of $51,000, or $3,570 per employee. This per employee cost would fall proportionally for average per employee payrolls below $51,000 per year. The cost of the private insurance at an average employee contribution of $300 per month would be $3,600 per year for all employees. Consequently, the cost of Americare would be less for all employers with average per employee payrolls of less than $51,000 per year. The small business tax credit would not change this as it is phased out at lower income levels where the Americare tax would still be less than the private insurance premiums even with the credit. At $15,000 in wages, where the tax credit begins phasing out, the 7 percent Americare tax would cost $1,050 per year. But $300 per month for the private insurance with a 25 percent credit would still cost $2,700 per year. While the legislation specifies that the tax rate should be set so that at least one-third of the uninsured would be covered by private insurance, this is unlikely to occur unless the tax rate is raised sharply from its currently proposed 7 percent. More likely, the one-third requirement for private coverage will be dropped.

8 S. 1227 would use the same definition of taxable wages as Social Security without any maximum taxable income cap.

Opting for Public System. If the Americare tax rate is set far below the true cost, however, then far more employers would opt for the public system. At 7 percent, the Americare tax rate would be far below the true cost of either private or public coverage. The average private premium of about $3,600 per year per employee, which reflects true costs, amounts to about 14 percent for an employee earning the national average wage of $25,000. This is consistent with estimates that corporate health care currently costs about 14 percent of payroll for covered employees.[9]

Thus, all employers with average per employee payrolls of less than twice the national average wage would save money by dumping their workers into Americare.

For the Americare tax to be equal to the average cost of health insurance for workers with average earnings, the tax rate would need to be increased from 7 percent to 14 percent. Even at this higher tax rate, employers still would save money by dumping workers with below average wages into Americare.

Last week's Urban Institute study estimates the effects of such incentives using a sophisticated simulation model incorporating data on employers' health insurance premiums as well as population and payroll data. The study assesses a play or pay plan like that in the Mitchell bill, assuming a 7 percent payroll tax for employers choosing the "pay" option.

Huge Additional Costs. According to the Urban Institute, Americare would end up covering 52 percent of all Americans under age 65, or some 111,900,000 individuals. The Urban Institute study projects that 51.7 million workers and their dependents now covered by an employer-sponsored plan would be shifted into the public plan. The study finds that 81.5 percent of all the employees of small firms (less than 25 workers) would end up in the public plan.

Calculating the tax and the required benefit package for company-provided plans, the study estimates that the cost to American companies each year of paying the tax or providing health benefits would be $29.7 billion more

Annual Increased Cost in Health Insurance for Business Under Pay or Play

	billions of dollars	% increase costs
Small Firms	$11.0	+71%
Medium Firms	$ 9.7	+21%
Large Firms	$ 9.1	+13%
Total Extra Cost to Employers	$29.7	+23%

Source: Urban Institute/Department of Labor
Note: numbers may not add up due to rounding.

9 "Its Cheaper to Pay Than It is to Play"(Washington, D.C.: The NFIB Foundation, 1991), p. 8, citing *Business Insurance*, June 21, 1991.

than they currently spend on health insurance, an average increase of 23 percent. For small firms, the cost would be an average rise of 71 percent.

Despite these increases in costs, the Urban Institute study confirms that a 7 percent tax, combined with the schedule of premiums for Americare, would not cover the cost of the program. The shortfall, which would need to be covered by taxes beyond the new payroll tax, would be an estimated $36.4 billion each year.

Endless litigation would increase dumping.

Other factors too would prompt employers to abandon the private insurance coverage they now give their workers, even if the costs were roughly equivalent. These factors would increase the size of the public program beyond the Urban Institute's projections.

The most important of these factors is that by shifting their workers to Americare, employers would avoid the threat of being slapped with lawsuits alleging discrimination against existing employees who posed potentially high medical costs. If a worker or job applicant in poor health or with a large family (which thus costs more to insure) or is elderly were discharged or denied a job, he or she could sue the employer under the anti-discrimination provisions of S. 1227 and collect damages, including health care costs and possible stiff fines.

Just as under civil rights legislation, the pattern of hiring of every firm would come under scrutiny. If a company's work force were in general younger or more healthy than the population in the area, and it had chosen to provide its workers with health insurance, the firm could find itself embroiled in lawsuits alleging discrimination. Employers could avoid this costly quagmire of lawsuits, of course, simply by dropping private coverage and dumping their workers into Americare.

If employers paying the payroll tax lobbied Congress successfully to prevent the Americare tax rate from increasing in future years, and thus hold down their health care costs while the cost of private coverage increased, there would be a steady increase in the number of employers choosing the Americare option. As a result, the difference between the Americare tax and the true cost of the coverage would increase and require larger infusions of general tax revenues.

Thus under S. 1227, the majority of non-elderly Americans would be forced into the public Americare system, which essentially would become a massive Medicaid program. The broad middle class consequently would lose its current private insurance coverage and be consigned to a government-directed system with Medicaid levels of coverage and quality.

CONTROLLING COSTS BY DESTROYING QUALITY

In testimony before the House Budget Committee last July 24, Mitchell identified what was rapidly driving up the costs of American health care. He said:

> Many years ago, not by any grand plan or design to meet what was, in fact, an unmet need in our society, we began a process which has resulted in the separation of payment for health care from the receipt of health care services. That has met, to some

> degree, what was an unmet need; but it has, at the same time, created over-utilization and a problem of attitude with respect to the quantity of health care.

What Mitchell meant was that because so-called "third parties"—companies or the government—usually pay the bills, the payment for health care is not a direct concern of the consumer. Consequently, the consumer will demand ever more health care with little or no regard for expense. With the consumer unconcerned about costs, the physician or hospital is not concerned either. The result: rapidly escalating costs.

In this arrangement, providers of health care have little incentive to become more efficient. Indeed, efficient or productive providers actually are penalized with decreased income because value-for-money does not attract customers if those customers are unconcerned about the bill. Conversely, those providers who dispense more services regardless of their actual benefit, or charge higher prices, are rewarded with increased incomes.

Reversing Backward Incentives. The key to health care reform lies in reversing these backward incentives. But this will happen only when the consumers who demand health care also pay directly for medical services and insurance.

Although Mitchell apparently recognizes the problem, his proposed Health-America Act does nothing to address the separation of payment for health care from the receipt of services. To the contrary, the bill would extend and perpetuate the relationship at the root of the health care problem. Indeed, the third-party payment system would be further entrenched as a result of the bill's coverage mandates.

The employers who now finance most private third-party coverage, moreover, would lose most of whatever incentives and powers they now have to control costs. Many employers would abandon their current efforts to control costs and simply turn over their employees to the public program. Those choosing to continue coverage would find their ability to control costs weakened because there would be a national minimum for health benefits package. Worse still, this minimum package of benefits undoubtedly would rise substantially in cost over time, since if organized labor could not persuade companies to increase benefits at the negotiating table, unions would have the incentive to lobby Congress to raise the minimum benefits.

AN OLD-STYLE CENTRAL PLANNING NIGHTMARE

The Mitchell bill does not try to address the cost escalation by introducing incentives for consumers to consider value for money in insurance or medical services. Instead, the bill in effect rejects the market approach entirely and tries instead to control costs by establishing a sweeping, central planning bureaucracy to run the entire U.S. health care system, including the privately insured sector. The bill is extraordinarily ambitious in the scope and rigor with which it would remove every remaining aspect of normal market functions and replace them with a vast central planning apparatus. The Mitchell bill, in short, would turn over

about one-eighth of the American economy now spent on health care (over $700 billion) to the kind of central planning now being abandoned around the world.

Regulatory Nightmare. The central planning system envisioned by the Mitchell bill would dwarf in complexity and scope those found in the national health systems of other Western countries. Government regulation of health care spending and services in Britain, Canada, or Sweden, for example, actually is quite crude and simple compared with the apparatus proposed by S. 1227. Even so, these nations have not escaped the inevitable shortcomings of central planning: shortages, rationing, and waiting lists. Indeed, Britain and Sweden now are seeking to introduce market-based mechanisms in a desperate effort to deal with the serious problems facing their health systems.

Ignoring the accumulated weight of evidence detailing the failure of central planning in health care or elsewhere, the Mitchell bill would establish a Federal Health Expenditure Board to set annual health expenditure limits for the entire country, with quotas for each state and health care sector. The Board would convene planning committees consisting of supposed representatives of health care providers and consumers to negotiate terms and conditions for health care delivery and payment throughout the nation. Thus, instead of the normal market incentives and competition that assure quality and price restraint in the rest of the economy, the Mitchell bill counts on an all-powerful planning board to accomplish this task.

Adding yet another layer to this bureaucratic structure, each state would be required to establish a Quality Improvement Board. These boards essentially would set "guidelines" for medical practices and procedures in their respective states. Such guidelines, of course, likely would be mandatory, given the central dictation of fees and direction of resources. Instead of consumers determining what services they want and what price and quality they consider acceptable, government boards and agencies would issue pronouncements on what services are worthwhile and what constitutes good value.

Limits Make No Sense. While some policy makers in health care are fascinated by the idea of national expenditure limits, most economists recognize they make no sense. A national board and its various committees have no way of knowing what total health expenditures in America or a state "should be." The correct amount of such expenditures can only be determined through the decentralized market process based on millions of choices made by individuals faced with competing providers.

Expenditure limits set by a national board can only be arbitrary, and if they are lower than the amount that consumers want to spend, the result inevitably is shortages. This means that some Americans will be denied care. This is true whether the central planning committees are composed of ostensible representatives of interest groups, government officials, and academic experts, or whether individuals are picked at random from a phone book. Indeed, populating the committees with representatives of interest groups as S.1227 would do, would give most power to well-organized special interest groups and least to ordinary Americans.

HOW QUALITY WOULD SUFFER

The bill's central planning regime would reduce the high quality of health care now enjoyed by the average American. As in the British, Canadian, or other nationalized health systems, the bill's proposed expenditure limits would restrict resources devoted to medical care, forcing providers to ration care. In particular, the expenditure limits and restrictions on capital investment envisioned in the bill would limit and delay the purchase of technologically advanced equipment, and the maintenance and expansion of facilities. Such limits in Canada have slowed significantly the rate of introduction and the availability of new technology.

Under the Mitchell bill, there would not only be a financial restriction on new technology, but developers of new equipment first would have to convince technology assessors and outcome measurers at the Federal Health Expenditure Board, state Quality Improvement Boards, and the Public Health Service that the innovation was worthwhile. Then the innovator would have to persuade the Federal Board and numerous state and specialty committees to approve compensation levels to physicians and hospitals operating the new technology.

These bureaucrats would have no economic incentive to ensure quality improvement; their top priority would be to avoid new costs in order to meet the system's expenditure limits.

For the great majority of workers, locked into Americare, quality would be further threatened by the fee schedule in the program. States no doubt would exercise their authority under the bill to use the Medicaid reimbursement rates for the first six years under Americare, as permitted under the bill, because these rates are so much lower than the Medicare rates seen by the bill's sponsors as the eventual basis for Americare payments to physicians and hospitals. Because of the low fee rates under Medicaid, the services generally are of the lower quality than under today's private plans.

The current American medical system provides the average insured worker or family member with routine access to higher quality and more sophisticated care than anywhere in the world. The HealthAmerica Act would systematically undermine this high quality of care for the average family.

THE MOST IMPORTANT EMPLOYEE BENEFIT—A JOB

The primary aim of the Mitchell bill is not to control costs, but to extend coverage to Americans who today have no health insurance. Yet these very individuals would find their jobs threatened under the bill.

The uninsured tend to be workers, or the dependents of workers, in small and start-up firms. These firms find it hard to afford insurance because they lack the number of workers needed to obtain a good insurance rate and because many small firms could not be profitable if they offered generous health benefits.

Adding to Unemployment. If the owners of these small and new businesses are forced to pay a new tax on their workers or provide insurance, many would have to cut their work force or go out of business.[10] The bill consequently would mean that many of the uninsured would lose their jobs.

Employers could offset the added costs of the newly mandated insurance or payroll tax by reducing the wages of the currently uninsured. When this happens, the uninsured would benefit little from the bill, as they in effect would be paying for the insurance themselves. Given the minimum benefit package required by the bill, moreover, many of these workers would be forced to buy more insurance than they would choose or need. And if the Americare tax rate were increased to cover more of the program's costs, this would only add to the heavy financial burden on the uninsured or increase job losses.

The Mitchell bill meanwhile would affect some of the insured differently from others, and thus encourage changes in hiring patterns. Example: one way that employers could reduce their costs under the bill would be to use part-time rather than full-time workers. Part-time workers would be required to pay 50 percent of the premium cost, rather than only 20 percent of the premiums. Employers might well recast many currently insured full-time workers as part-time workers to reduce the cost of raising benefit levels to the required minimum.

HOW TO GET MORE FOR LESS

There are only two ways to reduce health care costs—or indeed the cost of any good or service. The first is to get "less for less." That is, to spend less by accepting less—less quality, less service, less technology, less benefits, less access.

The other way is "more for less." That is, to increase productivity so that less spending will buy more—more quality, more services, more technology, more benefits, and more access.

Adopting "less for less" is how every centrally planned nationalized health system in the world attempts to control costs. It is also how S. 1227 would attempt to control costs.

Obtaining more health care for less money can only be achieved through productivity increases in the delivery of medical care, which in turn, can only result from a normal market in which consumers have the incentive to choose the best value for money and in which providers who increase productivity are rewarded.

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10 Since the great majority of the uninsured are likely to be in firms with average per employee payrolls of less than $51,000 per year, they are likely to be covered by Americare rather than private insurance, as discussed above. The proposed small business tax credit consequently would have little or no effect in ameliorating these negative employment impacts. The bill's proposed exemption from the insurance mandate for small businesses implies recognition by the sponsors that the employment impact of the insurance mandate on small businesses would be a problem. Yet the exemption would only mean a delay in layoffs.

Forcing an employer to "pay" for an employee-family's health care is simply a hidden way, moreover, of making the employee pay for his or her own care, since the employer includes the cost of health care as part of the total compensation for the worker—which is determined by the market for labor. More health benefits ultimately means less cash wages. Thus, if some Americans cannot afford care, the proper policy is to help them directly to pay for it, not to adopt the illusion that an employer can be forced to pay.

Consumer Choice Needed. Only a sound, freely functioning market will reward the more productive (high quality, low cost) providers with more patients, and thus, higher incomes. A sound, freely functioning health care market will exist only when consumers directly purchase their own medical care and health insurance, and are thus rewarded with better health and savings in their pockets for buying from more productive providers. And only a change in the way that the government subsidizes Americans to buy health care and health insurance will enable lower-paid Americans to afford care—rather than simply forcing these workers to accept health insurance paid for with lower wages.

The Mitchell HealthAmerica bill will not create a consumer choice market in health care and thus does not offer Americans more for less. It offers, as do nationalized heath systems, less for less. In place of the Mitchell bill, Congress should consider reform proposals which would introduce consumer-choice market incentives into health care. Such a consumer choice health plan has been proposed by Heritage Foundation scholars.[11] The key elements of such a reform are:

- ☞ Consumers must be given control over the money spent on their health care and the power to decide how best to spend it;
- ☞ All Americans must receive, through the tax code, an equal incentive to purchase needed medical care and health insurance in whatever manner, or from whomever, they choose;
- ☞ All Americans thus will have health care;
- ☞ The tax code and public programs must be further reformed so that tax-based assistance to Americans with low incomes or high medical costs is sufficient to increase their purchasing power in the medical marketplace so that they can afford the care and insurance they need. Simultaneously, the structure of tax assistance to other Americans must be changed to encourage them to seek better value for money rather than, as today, heavily subsidizing generous health plans for high-income Americans.

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11 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. 77, 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.

By giving health care funds and health care tax relief to Americans directly, instead of indirectly through company-based plans, workers and their families would have a much wider choice of health care packages. By being able to choose a health plan from a source other than their place of work, their health care would be separate from their employment. No longer would a change of job mean a change of benefits or, worse still, the loss of benefits. No longer would losing a job mean losing health benefits.

CONCLUSION

The HealthAmerica Act has been touted as a compromise between America's current health care system and a Canadian-style government-run national health care. It is nothing of the sort.

The incentives created by the Mitchell bill mean that the play or pay system quickly would collapse into a full-blown, government-run, taxpayer-financed, national health care system, with all the features of such systems that would be unacceptable to most Americans—long waiting lines for care, explicit rationing of care, and limits on a patient's choice of doctor and treatment.

The play or pay model of health care reform is, in short, a political bait and switch. The bait is the notion of building on today's employment-based system. The switch is a super-Medicaid program that few Americans want. Significantly, congressmen have made sure in the bill that they would not be included in the system they tout as best for other Americans.

Market Incentives. What is needed instead is a consumer-choice, universal health care system. Such a system would create market incentives to increase productivity in the health care delivery system by simultaneously cutting costs and boosting quality and effectiveness. This is the system that works in the rest of America's economy, and by changing the current perverse incentives in the employment-based system it would work in health care. The result would be an American health care system that offered Americans the best health care value for their money. Such an achievement would be the envy of the world.

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