The Heritage Foundation Backgrounder

No. 924 | The Heritage Foundation 214 Massachusetts Avenue N.E. Washington, D.C. 20002-4999 (202) 546-4400

January 12, 1993

THE CONTRADICTIONS IN THE CLINTON HEALTH PLAN

INTRODUCTION

Lawmakers returning to Washington are sensing an increased momentum toward health care reform. While there was little real debate in the presidential campaign over the specifics of health care reform, both major candidates were committed to major structural reforms designed to assure universal access to health care for Americans at reasonable cost. And candidates for Congress found health care high on the agenda of most voters.

The new Congress seems destined, therefore, for a serious debate on health care reform, and possibly for the passage of comprehensive legislation. But it will be no easy task to enact legislation that will both work and satisfy the American public. Surveys of public opinion continue to show confusion and uncertainty about what Americans want.[1] And politicians who misread the public mood are likely to face a severe reaction from constituents. As lawmakers well remember, Congress overwhelmingly passed the Medicare Catastrophic Act in 1988, only to repeal it the following year due to public pressure.

Still, with Bill Clinton in the White House, the Administration and the congressional leadership feel pressure to enact legislation. Clinton developed a proposal during the campaign, and his advisors now are reshaping it into a major Administration initiative. That is likely to be the basis for any legislative measure.[2] The problem is that the proposal is seriously flawed.

1 For an analysis of public opinion on health care, see John Immerwahr, *Faulty Diagnosis: Public Misconceptions About Health Care Reform* (New York: Public Agenda Foundation, 1992). For the problems associated with understanding public opinion polls on health, see Daniel Yankelovich, "How Public Opinion Really Works," *Fortune*, October 5, 1992, pp. 102-108.

2 Proposal released by the Clinton campaign headquarters, September 24, 1992.

The most obvious defect of the current Clinton proposal is that it tries to combine in one measure two completely contradictory strategies for reforming the health system. On the one hand it incorporates all the bureaucratic apparatus of rigid national budgets, sweeping price controls, and powerful boards to determine what medical care Americans will receive. But on the other hand, it also incorporates features of a strategy based on consumer choice and competition.

Specifically, the Clinton proposal would:

- ✔ **Establish a fixed national health budget,** developed by a National Health Board;

- ✔ **Establish local managed care networks,** which would receive a fee to provide medical services. Providers outside these networks would be subject to price controls and budget limits;

- ✔ **Require all employers either to provide coverage to their employees or to enroll their employees in a managed care network.** Unemployed Americans and Medicaid recipients could join a network, with the government paying part or all of the premium;

- ✔ **Require all insurers to offer a comprehensive set of health services,** determined by the National Health Board, and to charge enrollees a premium without regard to health risk. Insurers could no longer deny coverage to anyone.

Other proposals, including a bill developed by the Conservative Democratic Forum in the House, would include versions of the Clinton consumer choice strategy but do not include his provisions for fixed budgets and price controls. These generally are known as "managed competition" proposals.

While the entire Clinton plan suffers from the oil-and-water problem of two strategies that will not mix, there are many other flaws. Among them:

- ✘ For a fixed national budget to mean anything, it must incorporate explicit rationing, which is inefficient and rejected by the vast majority of Americans by margins of nearly four to one.[3] Otherwise it is nothing more than a spending target and will succeed only if other cost controls work. Unfortunately for Clinton, America's experience with health care price controls and entitlement programs suggests the "national budget" will be meaningless.

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3 For example, a recent EBRI/Gallup survey, completed in October 1992, found only 20 percent of Americans prepared to accept limits on the health care available to the average person. See John Immerwahr, *Rationing Health Care: A Public Perspective*, paper presented December 1, 1992, at a forum sponsored by the Employee Benefit Research Institute in Washington, D.C.

- ✘ Establishing a standard benefits package for Americans will encourage heavy lobbying by medical specialties to be included, much as they have lobbied successfully at the state level to be included in "mandated benefits" laws. The likely result: a steady increase in the cost of the basic package.

- ✘ Place of employment would continue to be the primary determinant of the health care available to each family. Changing jobs often would mean changing plans and doctors.

- ✘ By not significantly reforming the tax treatment of health care, the Clinton proposal locks in many of the perverse incentives and inequities of the current tax code.

Consumer choice and competition should be at the heart of any structural reform of America's health care system, as Clinton has suggested. But that means rejecting the remnants of health care central planning contained in the Clinton proposal. Instead it means enacting a major reform of the tax code to give Americans the incentive and the means to choose the plan that is best for them within a framework of wide choice and strong competition. With that reform in place, America could achieve the illusive goal of affordable access to quality care for all its citizens.

WHY AMERICANS WANT HEALTH CARE REFORM

Dissatisfaction with the health care system is higher in the United States than in any other major industrialized country. Polls routinely show that well over 80 percent of Americans want the system "completely rebuilt" or feel it needs "fundamental change."[4] By comparison, less than 50 percent of Canadians or Germans believe that such a level of change is necessary in their systems.

Politicians should be wary, however, of assuming that this high level of dissatisfaction means that Americans want big changes in the way that they themselves receive health care. A 1992 national survey, for instance, found only 26 percent were dissatisfied with the health care services their family received during the last few years.[5] What concerns Americans most is that their employer-provided benefits will be cut back, or that the cost to them of medical care will become prohibitive.[6]

There is a good reason why families are anxious, even if they currently have good insurance and are receiving excellent care. That is because for working Americans, health care benefits invariably are tied to the place of work. Not only are there historical reasons for this, but because the tax code treats health care benefits as tax-free income if they are supplied by an employer as part of a worker's compensation, there are also strong incentives for health care to be provided in this way.

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4 Robert J. Blendon and Karen Donelan, "The Public and the Emerging Debate Over National Health Insurance," *The New England Journal of Medicine*, 323, July 19, 1990, pp. 208-212.

5 The 1992 Kaiser/Commonwealth Health Insurance Survey.

6 *Ibid.*

This tax-preferred employment-based system leads directly to the characteristics of U.S. health care that cause so much concern.[7] Among these:

- ✘ **A lack of portability.** With health benefits tied to the place of work, moving jobs or being laid off can mean the loss of benefits, or at the very least having to join a different health plan, often with various restrictions on pre-existing conditions and other limits. One result of this is "job lock," the phenomenon where workers feel unable to take a better job for fear of losing coverage. Some 30 percent of Americans say a member of their household has experienced this.[8]

- ✘ **A high level of uninsurance.** With tax advantages effectively restricted to employer-sponsored group coverage, workers without a company plan often find purchasing their own health insurance prohibitively expensive. This is why about three-quarters of the uninsured are workers or their dependents. This problem is compounded by the underwriting and renewal practices of insurers, which makes coverage virtually unobtainable for families with a poor health record.[9]

- ✘ **Rapid cost escalation.** Even though company-provided benefits actually are part of a worker's gross compensation—not "paid for" by employers—workers tend to think of benefits as "free" or involving little direct cost to themselves. Moreover, the group underwriting of employment-based health insurance means that individual employees do not typically face higher costs (other than, possibly, copayments) because of their own usage of services. As a result, there is usually little or no incentive for workers to limit their consumption of unnecessary care, or to seek the best value for money. This is the main reason why health care costs are increasing at several times the general rate of inflation.

To be sure, there are other features of the U.S. health care system that contribute to the dissatisfaction and financial worries of Americans. Among these are excessive insurance paperwork (often encouraged by employers to slow down the volume of claims), and the various effects of large malpractice settlements (such as the lack of certain specialties in some areas). But the core of the problem is its employment-based design.

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7 For a fuller description of the design of the current system and its consequences, see Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I," Heritage Foundation *Talking Points*, March 5, 1992.

8 1991 New York Times-CBS poll cited by Paul Starr, *The Logic of Health-Care Reform* (Knoxville, Tenn.: Whittle Direct Books, 1992), p. 21.

9 See Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part III: What's Wrong with America's Health Insurance Market?" Heritage Foundation *Talking Points*, October 1, 1992.

THE CLINTON PLAN

The Clinton transition team currently is developing a full proposal, expected to be sent to Congress early in the new Administration. But President-elect Clinton did spell out the broad outlines of his preferred approach during the campaign. The plan aims to limit health cost increases to the same growth rate as wages, to guarantee affordable, quality coverage for all Americans, and yet to preserve personal choice of doctor and hospital.

How the Plan Is Meant to Work

1) Controlling Costs

- ✔ The plan would establish a **national health budget**, covering total private as well as public expenditures. This figure would be developed by a **National Health Board** consisting of representatives from the public, providers, business, labor, and government. The national budget would be broken down into **global budgets** for states and possibly networks of hospitals and doctors.

- ✔ Within this budget limit, most Americans would have access to a choice of **local managed care networks**. These organized systems of insurers, hospitals, and doctors would receive a fixed amount of money from employers or the government, known as a **capitation fee**, for supplying an enrollee's full medical services. The fee would be set by each state, to meet its share of the national budget.

- ✔ Other Americans, at the discretion of their employers, would be enrolled in company-sponsored health insurance plans. For such services provided outside the managed care networks, states would introduce fee schedules for doctors and hospitals corresponding to the global budget.

- ✔ Medicare would be subject to a budget limit and to existing physician and hospital fee schedules.

- ✔ Certain tax breaks would be eliminated for pharmaceutical companies that raised their drug prices faster than the rate of inflation.

2) Universal Coverage

- ✔ All employers would be required to provide coverage to their employees and families, either directly from insurers or through the managed care networks. Employees would be required to shoulder a portion of the cost. Small employers would receive tax credits to help offset the cost of the mandate.

- ✔ The health insurance deduction for the self-employed would be raised to 100 percent of coverage cost, up from today's 25 percent.

- ✔ Insurers would face new requirements. They would have to offer a comprehensive health benefits package, determined by the National Health Board. They would no longer be able to exclude any family from enrolling

in their plan, whatever their health record. Insurers would also be required to charge **community rates**, which means premiums to be set regionally, without regard to the insurance risk posed by an employee or group of employees, or to administrative factors (such as the size of an enrolled work force). And insurers also would have to introduce a single, standardized claim form.

- ✔ The government would band together small businesses and individuals into publicly-sponsored purchasing groups. Health networks would then have to compete for the business of each individual or business. This feature of the Clinton plan is generally known as **managed competition**.

- ✔ Non-working families would be included within the publicly-sponsored purchasing groups, paying a sliding scale rate for coverage based on income. Medicaid recipients would be folded into this system and thus obtain private coverage.

The curious thing about the Clinton plan is that it consists of two completely contradictory approaches. One approach relies on price controls and rigid government-imposed budgets to constrain costs. This would operate through the National Health Board, and Medicare-style fee schedules enforced by an army of bureaucrats. The other approach still incorporates extensive regulation, but relies on the powerful forces of consumer choice and market competition to keep prices down in an efficient manner. This would operate through the institutional framework of managed competition.

The Clinton plan thus tries to blend together two approaches with quite different pedigrees. The budget and price control approach incorporates the central features of national health insurance, favored by those who call for a version of the Canadian or British health systems. The managed competition approach, by contrast, is advocated by individuals who tend to be very hostile to price controls. The managed competition model was developed by Stanford professor Alain Enthoven, with University of California Professor Richard Kronick.[10] Modified versions are being advanced by a group of scholars, policy makers, business executives and health industry leaders known as the "Jackson Hole Group," and by the Washington-based Progressive Policy Institute.[11]

The Conservative Democratic Forum Bill

On Capitol Hill, a managed competition bill was introduced in 1992 in the House (H.R. 5936) on behalf of the Conservative Democratic Forum (CDF) by Representative Jim Cooper, the Tennessee Democrat. Significantly, the CDF bill contains no fixed national budget or price controls. And while it would set up a national health board, that body's functions would be confined to determining and updating a standard benefits package, and to establishing general standards for pricing and service information, "much like the Securities and Exchange Commission oversees the financial market."[12]

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10 Alain Enthoven and Richard Kronick, "A Consumer Choice Plan for the 1990s," *The New England Journal of Medicine*, 320, January 5, 1989, pp 29-37 and 320, January 12, 1989, pp. 94-101.

11 See Jeremy Rosner, "A Progressive Plan for Affordable, Universal Health Care," in Will Marshall and Martin Schramm, eds., *Mandate for Change* (New York: Berkley Books, 1992).

The main features of the CDF bill are refinements of the same managed competition approach used in the Clinton plan. Among the specific provisions of the CDF bill:

- ✔ Tax and regulatory incentives would be given for health care providers and insurance companies to form networks known as **Accountable Health Plans** (AHPs). These plans would have to offer a standard, federally determined plan—although they could also market more elaborate plans. As in the Clinton proposal, AHPs would have to price their product using a form of community rating, with variations in premiums based only on geographic location and to a limited degree based on age. Plans would have to enroll individuals regardless of medical condition.

- ✔ Currently an employer may deduct from taxable income the full cost (without limit) of health benefits included in an employee's compensation. Workers may exclude the value (again, without limit) of those benefits from their taxable income. More modest tax breaks are available for the self-employed and those experiencing high out-of-pocket medical costs. Under the CDF bill, the employer's tax deduction would be limited to the cost of the lowest-priced AHP in the area. The extra cost of more elaborate plans provided by the employer would be added to the firm's taxable income. Individuals who pay all or part of the premiums of an AHP plan would be able to deduct the full amount. Individuals or firms purchasing non-AHP plans would receive no tax breaks. In the Clinton proposal, there is no discussion of tax changes.

- ✔ State-chartered not-for-profit **Health Plan Purchasing Cooperatives** (HPPCs) would be established. These would have the exclusive right in a region to organize a set of Accountable Health Plans. Businesses with fewer than 1,000 employees would have to join a HPPC. At the state's discretion, larger firms might effectively form their own HPPC. HPPCs would collect all premiums from individuals or firms and make payments to health plans according to the health risk of each plan's enrollees.

- ✔ Medicaid would be replaced with a new federal program to enable all families with incomes below 200 percent of the state's poverty level to obtain coverage through a HPPC. Families with incomes between 100 percent and 200 percent of poverty would pay premiums according to a sliding scale, based on income. The states would be relieved of the burden of acute medical care, but would have to take over responsibility for long-term care.

12 Undated description of H.R. 5936 released by the Conservative Democratic Forum.

PROBLEMS WITH THE CLINTON PLAN

The Clinton proposal undoubtedly served the purposes of an election campaign, for it contained elements from the major competing plans espoused by different factions of the Democratic coalition. But that is the central flaw in the proposal. It would mean a national health care system combining two contradictory strategies—central planning with price controls, and consumer choice with competition. Rather than combining the best of each strategy, it would in reality mean the worst of each. If enacted, it is destined to collapse in chaos as competing health care providers seek to evade price controls and shift their costs to less regulated sectors, government bureaucracies expand to try to stop evasion, and consumers grumble at the red tape and rationing while exploiting every loophole in the regulations.

But the proposal does not merely suffer from this self-destroying internal contradiction. Its core elements have their own serious weaknesses.

Why Global Budgets With Price Controls Cannot Work in the U.S.

Many Americans find the idea of a national health care budget very appealing. Why not simply establish some total amount the country will spend on health care, and then distribute these resources efficiently and fairly? If it were that simple, there would be good reason to apply the same approach to every other sector of the economy. A global budget for housing, perhaps, and one for automobiles. By simply declaring such budgets, and enforcing them, Americans presumably could end inflation in every sector, improve efficiency, and have billions of dollars in savings to spend on extra goods and services. It sounds too good to be true.

It is, of course. The central problem with such an idea is in a sense semantic: either a national budget means something or it does not.

Option 1: A Meaningful Budget. If a national budget really means something then it means Americans as a whole, by law, can spend only a certain amount on their health care. Once that figure is reached, say on December 12th in a particular year, health care services must cease, hospital doors must be closed and doctors' offices shut down. To be sure, well-managed hospitals and prudent doctors can spread their resources carefully over a whole year, as they try to do in Canada, so that there is no end-of-year shutdown. But even that will happen only if each hospital or group of providers has its own government-mandated budget, which means another extensive layer of bureaucracy. Otherwise each hospital or doctor has the incentive to maximize earnings without regard to any national or state budget. If every provider is, in a sense, cutting a slice from a limited pie, none has the incentive to cut a small slice so that someone else can cut a larger one.

Setting a global budget for any part of the health care system also begs a question—what counts as health spending? If a hospital's budget is controlled, how does the government deal with the explosion of spending that no doubt would occur in substitutes for hospitals, such as clinics, skilled nursing homes, and even doctors' offices. A budget might be set for prescription drugs, but what about non-prescription medications, such as antihistamines, cough syrup, or aspirin? Every attempt to clamp down on one

definition simply would mean an increase in spending somewhere else less subject to control.

But for lawmakers, the biggest problem is that for a global budget to mean anything, it must involve denying some Americans health care they are willing and able to pay for—in other words, to ration care. While the citizens of some countries grudgingly accept explicit rationing, surveys of public opinion in the U.S. suggest that Congress and the new Clinton Administration risk an enormous backlash if they enact a rationing system.[13]

Moreover, attempts to mitigate the aspects of rationing that would most offend Americans are not likely to succeed. For example, rationing is made more palatable and humane in Canada and Britain because the particulars of the rationing system for the most part are carried out by physicians. With his or her eye on the budget, it is the doctor who makes case-by-case decisions that match course of treatment with available funds. This works tolerably well because patients are far more inclined to accept rationing by their doctor than by some faceless official in the department of health, and unlike the official, the doctor can take into account the many unique and subjective features of an individual patient.

This leads some advocates of rationing in the U.S. to call for the rationing decision to be made as close as possible to the patient, ideally by the doctor. To be sure, that would fit in with the attitudes of most Americans. Most Americans strongly oppose rationing. But when asked who should make rationing decisions if that were the law, they overwhelmingly want their own doctor or local doctors to do so.[14] Government officials come well down the list of preferences.

But it is difficult to see how such a localized rationing system could function in the U.S. without a sweeping overhaul of the malpractice laws. In Canada or Britain a patient may be angry when a doctor refuses care, but he must accept it. In America the patient hires an attorney and sues when he does not like the doctor's decision. Yet Congress shows little inclination to confront the powerful trial lawyers' lobby and provide health practitioners with the type of immunity enjoyed by Canadian or British doctors.

At the other extreme, other advocates of rationing—including, it appears, President-elect Clinton—would entrust detailed guidelines over what health care Americans will or will not receive to some independent national board, a kind of "Supreme Court of Health." Such a board supposedly would be immune from public pressure, much like the Federal Reserve Board or the U.S. Supreme Court, and its edicts would carry the force of law. Not surprisingly, rationing by an independent board is among the least preferred options of an American public which is in any case overwhelmingly opposed to rationing. And even if such a board were beyond the political reach of patients angry at its decisions, the creators of the board—Members of Congress—would not be.

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13 See footnote 3.

14 EBRI/Gallup Poll, cited in Immerwahr, *Rationing Health Care*.

Option 2: A Meaningless Budget. But a national budget may in practice be devoid of any real meaning other than a hoped-for outcome. In other words, it may be like any entitlement budget within the federal budget—not a limit on spending but merely the projected spending outcome of other policies. In this case, for Mr Clinton's "national health budget" to grow no faster than the increase in wages (which averaged 6.2 percent during 1980-1991, compared with a health care expenditure growth averaging 10.3 percent during the period), as he desires, his other cost control measures must prove far more effective than any strategy currently used widely in the public or private sectors.

The private sector's strenuous efforts at cost control, for instance, still resulted in an average annual premium increase of 14.4 percent between 1980 and 1991, compared with an average rise in the Consumer Price Index of 4.7 percent. And in addition, per capita spending on health care grew during the period at an average annual rate of 9.3 percent.[15] Even the successful Federal Employee Health Benefits Program (FEHBP), the nearest existing model to a functioning managed competition system, could only keep the average annual increase in premium costs down to 10.8 percent during the period. And with over five times as many bureaucrats, and 30 times as many pages of regulations, as the FEHBP per covered enrollee, Medicare costs still swelled at an annual rate of 9.7 percent.

Medicare's experience with price controls should give cold comfort to Clinton aides who see price controls as the key to achieving a global budget. Medicare's attempt in the 1980s to hold down costs with standard fees for each treatment quickly led to an explosion of Medicare physician costs, as hospitals shifted costs to evade controls. Moreover, hospitals which played by the rules lost money, while those that gamed the price controls prospered. Attempts to limit physician costs through government fiat have had similar results. Many conscientious doctors have found their incomes falling while others maximized their incomes by such tactics as shorter and more frequent office visits for patients, and by routinely using procedures and diagnoses that yield high reimbursements.[16]

Problems with Managed Competition

Managed competition proposals tend to differ according to where they place the emphasis—on "managed" or on "competition." The Clinton plan, for instance, stresses government management. It incorporates a national board with sweeping powers to set budgets, determine benefits packages and, in some areas, fix treatment prices. Thus competition would operate within a tightly organized framework of government controls. The Jackson Hole proposal, by contrast, is less rigid, but even this incorporates various boards and federal rules to limit and direct competition.

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15 *Comparison of Premium Trends for the Federal Employees Health Benefits Program to Private Sector Premium Trends and Other Market Indicators*, unpublished study conducted by Lewin/ICF, Arlington, Virginia, 1992.

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

Each of these proposals, of course, exists only in theory. The interesting thing about the Federal Employee Health Benefit Program, the only existing national managed competition program, is that it incorporates relatively little direct management. The heart of the FEHBP, which covers over nine million federal workers, retirees, and dependents, is an annual choice of health plan, known as "open season." Federal workers are presented with a set of competing plans, with information on premiums, services, and likely out-of-pocket costs. They then pick the plan they consider the best value, with about two-thirds of the premium cost paid directly by the government. While the system is managed by the Office of Personnel Management, OPM's main function is to assure an orderly open season, determine whether competing plans meet basic criteria, and remit premiums to the relevant plans.[17]

The FEHBP is by no means perfect, but it does offer a useful real-life model as a benchmark for analyzing the managed competition component of the Clinton Plan, as well as the Conservative Democratic Forum's managed competition legislation. This, together with other analysis, suggests that significant reforms are needed in the proposals.

Problem #1: Price controls don't mix with competition.

Price controls introduce huge distortions into a market. Combining them with a strong dose of competition and consumer choice only aggravates the problem, as patients and providers make choices and decisions based in many cases on artificial prices. And complex price controls are unnecessary if a strong market exists. Significantly, even though the FEHBP includes several fee-for-service health plans, it does not impose Medicare-style price controls on physicians or hospitals.

Solution: Abandon price controls in the Clinton plan, including for Medicare, and allow competitive markets to control costs. Let consumer choice of plan, or direct payment for medical services, be the instrument of cost control.

Problem #2: Basing a family's choices of plan to those offered through an employer-based co-operative retains many of the drawbacks of today's employment-based system.

Under the Clinton plan, the place of employment still would determine the range of health plans available to a family. Each company could calculate whether its bottom line would be better if it continued to provide insurance, or simply dumped its employees into a managed care network. This is the same dumping incentive for employers that would result in millions of Americans losing their current coverage under the major "play or pay" bills languishing in Congress.[18]

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17 For a full description of the FEHBP, see Robert E. Moffit, Ph.D., "Consumer Choice in Health: Learning from the Federal Employee Health Benefit System," Heritage Foundation *Backgrounder*, No. 878, February 6, 1992.

18 See Edmund F. Haislmaier, "The Mitchell HealthAmerica Act: A Bait and Switch for American Workers," Heritage Foundation *Issue Bulletin* No. 170, January 17, 1992.

In the CDF plan, place of employment also determines the range of plans available to a family. Thus although insurance reforms would mean a family could always have access to a plan, changing jobs would in many cases also require a family to change its coverage.

By contrast, almost all Members of Congress and other federal workers and retirees have the same range of choices in any given area.[19] This means that moving from a huge agency to a small congressional office, or retiring, does not force a change of coverage.

Value of Health Care Exclusion for Typical Families in 1991

Family Income	Valued Tax Exclusion
less than $10,000	$ 50
$10,000 - $14,999	207
$15,000 - $19,999	366
$20,000 - $29,999	594
$30,000 - $39,999	857
$40,000 - $49,999	986
$50,000 - $74,999	1,373
$75,000 - $99,999	1,427
$100,000 or more	1,463
All Families	**$ 802**

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

Solution: Take an individual's place of employment out of the equation by allowing families in any large geographic area to enroll in any available plan. Under this arrangement, the HPPCs envisioned in the Conservative Democratic Forum bill would operate much as OPM does for federal workers. If large employers wished to offer a special range of plans to their own employees they could do so, but workers would not have to join a company-sponsored plan. In some cases, very large employers currently operating a plan might decide to spin it off as a subsidiary and turn it into an Accountable Health Plan open to anyone in a geographic area. Among other things, this would mean a worker could remain enrolled in the plan if he moved to another firm.

In addition, employers could be required to make payroll deductions, on the instruction of employees, and send premiums to each worker's chosen plan, as federal agencies and offices do for federal workers. This would reduce total administrative costs of the system and make premium payment simpler for most families. For the employer, it would be much like making a payroll reduction for an employee's chosen 401(k) pension plan.

Problem #3: Limiting plans to standard packages reduces consumer choice and innovation, and will lead to intense lobbying by specialty groups.

One concern expressed by many advocates of managed competition is that if rival plans can compete directly for customers, "cherry-picking" will occur. This means some plans will offer low-cost basic services aimed at healthy individuals, or give healthy individuals a discount to get their business, leaving less healthy families in increasingly expensive plans with more services. A related concern is that families

19 Some plans are restricted to certain categories of workers.

would sign up for a basic plan until they want extensive elective treatment, and then switch temporarily to a more elaborate plan. This "adverse selection" problem exists to a degree within the FEHBP, where each plan must charge all employees and retirees the same premium.

Most proponents of managed competition attempt to deal with this by designing a system to force plans to compete primarily on quality and price, not on the range of services they offer. Under the Jackson Hole Group and CDF proposals, for instance, a national board would establish a standard, comprehensive health package that all competing plans would be required to offer. This would be like all automobile companies making one standard vehicle, so that they could compete on the basis of quality and price, not by offering models with different equipment. Only the standard health package would be eligible for tax relief. Any additional services would have to be paid for in after-tax dollars. The Clinton proposal is less clear. Managed care networks would receive a budget-driven fixed annual fee "for meeting a consumer's full health needs." The National Health Board would determine the comprehensive package required of insurers.

There are several problems with this approach. For one thing it means that a government board determines the standard medical services available to all Americans—except for those willing and able to pay in after-tax dollars for additional services. This would be like requiring most Americans to drive the basic model of Chevrolet, while allowing a choice of luxury cars and imports for the rich. Innovative treatments, or alternative forms of health care, would have to wait for government approval as part of the standard package before they would be generally available to ordinary Americans.

A related problem is that every specialty would have a strong financial incentive to lobby hard to be included in the tax-preferred standard package. Specialty groups have lobbied successfully at the state level to be included in state-mandated insurance package. This has forced up the cost of health insurance and is a major cause of firms deciding to self-insure (federal law then permits exemptions from state mandates). With standard packages determined at the national level, the intense lobbying simply would move from state capitols to Washington, no doubt with the same cost-increasing results.

Solution: Rather than establish a standard comprehensive package, with tax relief limited to that plan, require a lean basic package but allow families to choose a selection of services beyond that and still obtain some tax relief (see below, #4). This would make the after-tax cost differential between a basic plan and an more elaborate plan less sharp, and so reduce the incentive for medical specialties — and organizations representing Americans with specific diseases — to lobby hard to be included in the base package. The FEHBP effectively operates in this way, with direct government assistance (approximately two-thirds of the premium cost, up to a maximum) taking the place of tax relief. Significantly, the standard requirements of FEHBP plans are minimal, and there is little pressure on Congress to expand them. Still, the market has evolved such that most plans do provide the services available in good corporate-sponsored plans.

To be sure, some adverse selection does take place in the FEHBP, and would do in a national system if plans could compete on the basis of services offered, rather than solely on price and quality. But that really only matters if plans are not able to vary

premiums to some degree according to risk. If they could vary premiums, competition would make cherry-picking less attractive by driving down the premium price for covering healthy families, while higher-risk families would mean good revenues for a competitive plan in the higher premium range.

There is a problem with this only if premiums reflecting risk become unreasonably expensive for families. This happens today. Supporters of managed competition could reduce that problem by permitting plans to quote premiums for new enrollees only within a specified band (say, up to 25 percent above or below a "standard" premium, according to risk) and without the right to turn down an applicant. This is known as "modified community rating." Existing enrollees would always be able to renew coverage at a premium increase no greater than the rise in the cost of the standard premium—irrespective of any change in their health status.

Still, requiring insurers to offer coverage to anyone, irrespective of medical condition at a fixed price (community rating) or even within a band (modified community rating) for a standard package of benefits, as proponents of managed competition would do, still leaves the insurers open to adverse selection by families. This problem is endemic to all forms of community rating, because it forces insurers to accept high-risk individuals without fully factoring their cost into premiums. A far better approach would be to subsidize high-risk individuals directly, and allow insurers to charge appropriate premiums to cover them. This can be done through the tax treatment of health coverage (see #4). The credits and vouchers would reduce the effective cost of more elaborate and expensive coverage for those families requiring it.

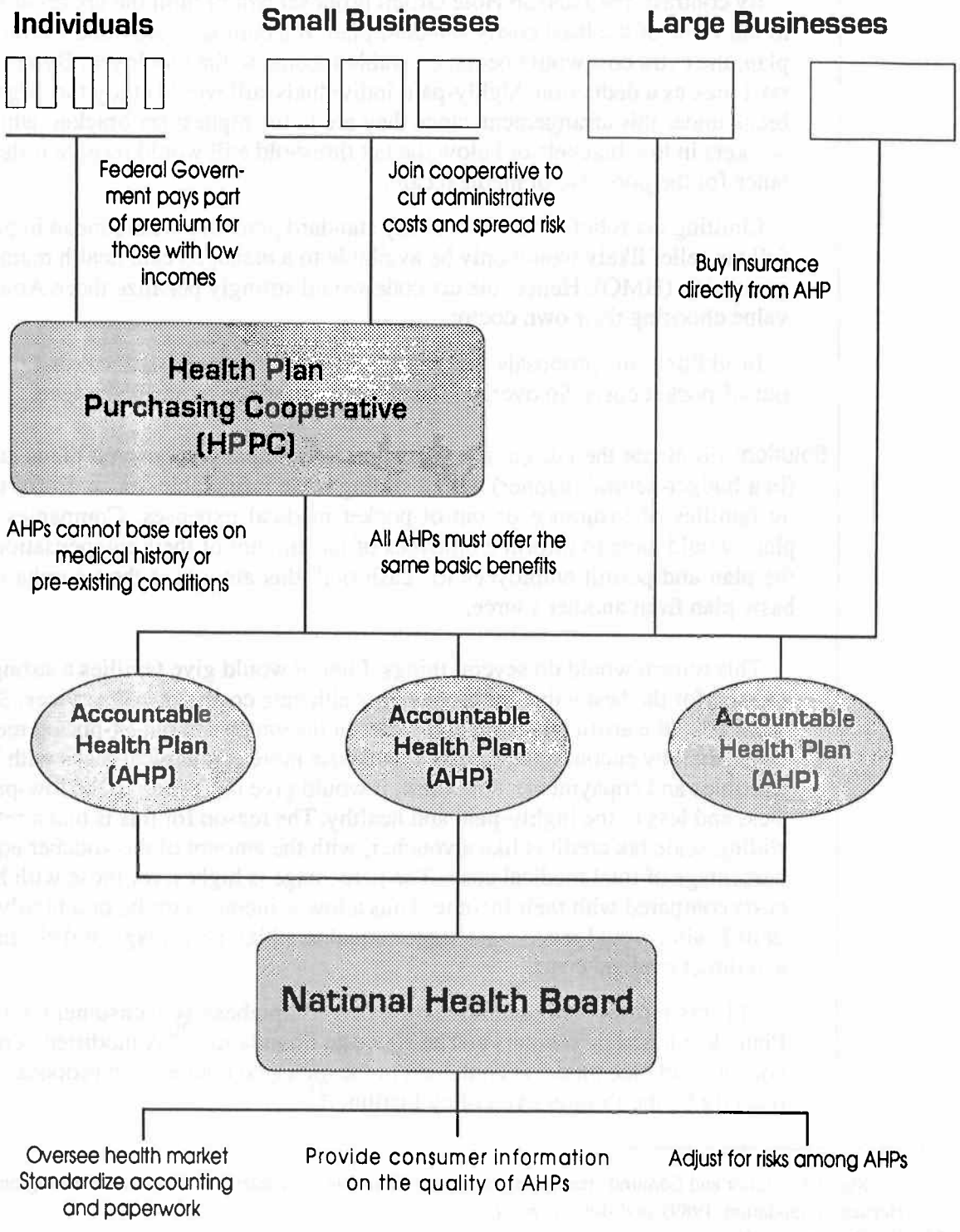
Problem #4: Most managed competition proposals do not sufficiently reform the tax treatment of health costs.

Today's tax treatment of health care costs discourages sensible choices by consumers. By limiting full tax relief to company-sponsored health plans, the tax code encourages gold-plated "company-paid" plans while penalizing any employee who would prefer a leaner plan offered outside his company. By providing relief only for premiums, the code encourages over-insurance, with employees routinely "insuring" themselves against such things as $5 prescriptions and routine dental care just to receive a tax break. The result is more costly insurance forms and little incentive for families to shop wisely for even the most basic medical items.

The tax code is also extremely regressive in the way it helps families afford care. As Chart 2 shows, the value of the health care tax exclusion is large for upper-income households with corporate plans, minuscule for low-paid workers with plans, and non-existent for those who work for firms without a plan. Reform of the tax treatment of health care is needed not only to correct the incentives in the current system, but also to assure coverage for the uninsured without any general increase in taxation.

The managed competition proposals generally do not adequately address the need for tax reform. Clinton has endorsed the idea of limiting the degree to which companies can deduct the cost of health care plans. The CDF bill would do nothing to change the tax treatment for employees, but it would introduce a tax penalty

How "Managed Competition" Would Work



Source: Conservative Democratic Forum.

benefits, yet leave well-paid employees with large tax breaks and all employees with the incentive to press for expensive company-sponsored plans while resisting reasonable attempts by firms to make workers more attentive to costs by paying more out-of-pocket for their coverage.

By contrast, the Jackson Hole Group proposal would limit the tax relief for families to the value of the least costly standard plan. If a company provided a more generous plan, the extra cost would become taxable income to the employee. By keeping the tax break as a deduction, highly-paid individuals still would enjoy the largest tax break under this arrangement, since they are in the highest tax bracket, while low-paid workers in low brackets or below the tax threshold still would receive little or no assistance for the purchase of medical care.

Limiting tax relief to the least costly standard plan also would mean in practice that full tax relief likely would only be available to a managed care health maintenance organization (HMO). Hence, the tax code would strongly penalize those Americans who value choosing their own doctor.

In addition, the proposals still would limit tax relief to insurance (or a plan), not to out-of-pocket costs. So overinsurance would continue to be encouraged.

Solution: Eliminate the current tax exclusion for company-sponsored plans and replace it (in a budget-neutral manner) with a sliding scale refundable tax credit for the purchase by families of insurance or out-of-pocket medical expenses. Companies with health plans would have to inform employees of the amount of their compensation devoted to the plan and permit employees to "cash out" this amount if they purchased at least a basic plan from another source.

This reform would do several things. First, it would give families a strong incentive to shop for the best value for money in health care coverage and services. Second, it would end the artificial distinction between insurance and out-of-pocket medical costs, thereby encouraging families to choose more economical plans with higher deductibles and copayments. And third, it would give more help to the low-paid and sick, and less to the highly-paid and healthy. The reason for this is that a refundable sliding-scale tax credit is like a voucher, with the amount of the voucher equal to a percentage of total medical costs. The percentage is highest for those with highest costs compared with their income. Thus a lower-income family, or a family generally in ill-health, would receive assistance equal to a high percentage of their insurance and direct medical costs.

This tax reform is the central feature of a comprehensive Consumer Choice Health Plan, developed by scholars at The Heritage Foundation.[20] A modified version of the consumer choice model is contained in the managed competition proposal advanced recently by the Progressive Policy Institute.[21]

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20 See Stuart M. Butler and Edmund Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989), and Butler, *op. cit.*

21 See Rosner, *op. cit.*

CONCLUSION: MOVING TOWARD COMPREHENSIVE HEALTH REFORM

While the Clinton proposal is so seriously flawed as to be unworkable, it does at least seem to recognize that the key to fundamental health reform in the United States is through the private sector. He is not offering—at least overtly—a reform along the lines of the Canadian system, and he has virtually abandoned the "play or pay" proposals championed by the congressional leadership. He seems to have accepted that he needs to unleash the power of consumer choice and competitive markets. Today these powerful forces for efficiency and cost control either are thwarted, or so distorted and misdirected by the tax code that they perversely encourage inefficiency and a surge in costs. President-elect Clinton, like an increasing number of lawmakers, recognizes that competition and consumer choice are crucial. The problem is that his proposal still is not really based on these forces. Other proposals advanced by lawmakers and organizations friendly to the incoming administration would do more to incorporate market dynamics into a national plan, but these, too, have serious flaws.

The modifications needed to make these consumer-choice proposals work effectively are contained in the comprehensive plan developed at The Heritage Foundation. The essential features of the plan are contained in S. 3348, sponsored in the Senate by Orrin Hatch, the Utah Republican. This plan would introduce tax and insurance reforms which would, in effect, open up an improved version of the federal employee health system to all Americans. It would allow them to choose plans offered by unions, churches, farm bureaus, or employer groups. They could make a choice without regard to their place of work. And the plan's tax reform would give Americans the means and the incentive to choose wisely and economically. And in doing so, it would provide all American families with essentially the same health system enjoyed for many years by their representatives in Congress.

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