THE HERITAGE LECTURES

441

Overdosing on Management: Reforming the Health Care System Through Managed Competition

By Robert E. Moffit

The Heritage Foundation

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

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

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

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

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

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

Overdosing on Management: Reforming the Health Care System Through Managed Competition

By Robert E. Moffit

In the ongoing debate over the future of America's health care system, there is both good news and bad news. The good news is that, on one level at least, we are reaching something of a national consensus. There is indeed a broad consensus emerging among both policy makers and the general public on what is wrong with America's health care system. Virtually all disputants in this growing national debate agree that costs are soaring into the stratosphere; that there are far too many gaps in insurance coverage for those people who do have health coverage; and that there are far too many people who have no health coverage at all, even basic catastrophic coverage to protect them and their families against the financial devastation of a serious illness.

But the bad news is that on the specific solutions to these various and related problems, the consensus breaks down. This is true not only among policy makers and policy analysts, but also among the general public as well. Indeed among the public, you will find that public attitudes are full of paradoxes and contradictions. The growing body of survey research seems to bear this out. You should not be surprised, for example, that if you were to ask the American people if they want national health insurance, something like the Canadian model, they might be likely to say yes—as long as it is not run by the government. It is easy to win popular approval for the bold and simple proposition of "free care for all"—as long as it doesn't cost me anything.

Now, the starting point of any discussion of reforming the American health care system, including reform along the lines of "managed competition," must begin with an understanding of what it is exactly we are trying to reform. Perhaps the best single summary of the current American health care system came from *Newsweek*'s economist Robert J. Samuelson: "We already have socialized medicine. Government pays 42 percent of health care and lavishly subsidizes private insurance through tax breaks." As Dr. Samuelson notes, our so-called private employer-based system, which covers most Americans through their place of work, is dominated by a huge, dramatically regressive and largely unexamined tax break for only one type of insurance, employer-based health insurance. This is the dominant feature of our health care system. And finally, the American health care industry—doctors, hospitals, clinics, insurance companies, pharmaceutical companies, medical equipment suppliers, and so on—is already one of the most highly regulated sectors of the American economy. Please keep in mind that whatever we do to "fix" this broken system, it is this peculiar, politically manipulated system that we are "fixing."

At least among policy makers, there is another emerging consensus: we are at a fork in the road. We have no choice but to take one of two paths. Either we open up the health care markets or we close the health care markets even more. Either we genuinely change the current, costly system, dominated by employer-based insurance and huge government outlays, and allow the

---

Robert E. Moffit is Deputy Director of Domestic Policy Studies at The Heritage Foundation.

This publication is based on his presentation to Republican members of the United States Senate at a conference of the Senate Republican Task Force on Health Care, Annapolis, Maryland, February 25, 1993.

ISSN 0272-1155.

American people more personal freedom of choice and introduce more genuine competition into the system, or, alternatively we can simply build on what we already have, make no structural changes in the tax structure and insurance markets and expand the role of government over the American health care financing and delivery system. If we follow this latter path, in effect we will close the system up even more, increase the role of bureaucracy, and expand the existing regulatory regime over providers and health insurance industry, reducing doctors and hospitals to the status of even more highly regulated public utilities.

As you know, The Heritage Foundation has proposed an alternative health care system dramatically different from government-based health care reform options, based specifically on the market forces of consumer choice and competition and embodied in comprehensive legislation (S. 3348) authored by Senator Orrin Hatch.[1]

In any event, it is fair to say that there has been, at least from our philosophical perspective at The Heritage Foundation, a genuine progress in the tenor and tone of the national debate. Three years ago, if you ventured to say that the American health care system needed a thorough overhaul, all of my fellow Washington policy wonks and nerds automatically would have assumed that you were talking about establishing a single-payer system, along the line of a Canadian-style government health care system. Such a system would have to be financed by huge and unprecedented levels of federal taxation.[2] This evening, that is clearly no longer the case. While a sizeable congressional faction still supports national health insurance, serious or comprehensive reform of the health care system does not now automatically mean socialized medicine along the Canadian or British models.

We have no choice but to take one of two paths. Either we open up the health care markets or we close the health care markets even more.

Likewise, eighteen months ago, if you asked my fellow Washington policy wonks and nerds, what was the leading candidate for comprehensive health care reform, they would most likely have pointed to "employer mandates." The leading version of the employer mandate idea was of course, "play or pay," the main reform option of your Democratic colleagues in both the Senate and the House. The "play or pay" option was politically convenient doubtless because the burden of reform, particularly any new payroll tax, was to be borne directly by a numerical minority, American businessmen. Under the terms of the "play or pay" proposal, American businessmen, including small businessmen, have a choice: if an employer doesn't offer health insurance to his employees, at a level determined by the federal government, he can pay an additional tax. Thus, the nifty lingo "play or pay."[3]

---

1 See Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992; Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage Consumer Choice Health Plan Reform," Heritage Foundation *Talking Points*, February 28, 1992; Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.:The Heritage Foundation, 1989).

2 See Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain About Their Health Care System," Heritage Foundation *Backgrounder* No. 883, February 19, 1992.

3 Stuart M. Butler, "Why 'Play or Pay' National Health Care Is Doomed to Fail," *Heritage Lecture* No. 329, August 14, 1991, and Edmund F. Haislmaier, "The Mitchell HealthAmerica Bill: A Bait and Switch for American Workers," Heritage Foundation *Issue Bulletin* No. 170, January 17, 1992.

Now the focus of the national debate has moved to "managed competition," the product of a group of scholars associated with the work of Professor Alain Enthoven of Stanford University and your previous speaker, Dr. Paul Ellwood, the head of the Jackson Hole Group. In one sense, the very fact that the focus of the debate is "managed competition" is an indication of genuine intellectual and political progress. For whatever differences my colleagues at The Heritage Foundation have with the distinguished proponents of "managed competition," Dr. Ellwood and Professor Enthoven recognize a central and fundamental truth that should dominate any discussion of health care reform, namely that market forces are retarded or frustrated in the current health care system. Professor Enthoven and Dr. Ellwood are also correct in trying to inject market forces into the health care system as a means of both reducing health care costs and expanding access for our citizens. For that effort, Dr. Ellwood and Professor Enthoven should be roundly applauded. The argument over managed competition does not center on the great "theological" questions of the debate—whether market forces are either beneficial or effective in weeding out the inefficiencies of the current system—but on the politically decisive question of how market forces are to be injected into the system. Few argue that government has absolutely no role to play. Even if one were to argue that government should have no role whatsoever in oversight or management of the health care system, that proposition would in any case be burdened by the political infirmity of its obvious disconnection with what you and your congressional colleagues see as your public responsibility. The problem is in configuring the proper devil in the detailed mix of market forces and government management.

My task here this evening is to give you some reason to pause—to rain, so to speak, on the managed competition parade. But like all parades, this is a moving target, and the flourishing banners of the growing number of contingents are varied and colorful. Even so, it is not clear to me that all of the marchers are in the parade for the same reasons, or even going in the same direction. While the managed competition approach is gaining a more popular currency beyond the Washington Beltway, it is an approach that is undergoing various mutations, reflecting both the exigencies of practical politics and differing programmatic or ideological inclinations. President Bill Clinton, for example, has embraced a comprehensive health care reform proposal, with a managed competition component at its core; the Democratic Leadership Council's Progressive Policy Institute (PPI) has also unveiled a comprehensive managed competition proposal, replete with tax credits for individuals and families; and the Conservative Democratic Forum (CDF), a group of influential conservative House Democrats led by Congressman Charles Stenholm of Texas, also favors the approach. Perhaps the chief health policy expert among conservative Democrats in the House, Congressman Jim Cooper of Tennessee has introduced a bill (H.R. 5936) which embodies the main ingredients of the managed competition agenda. Furthermore, a growing number of business, insurance, and professional medical organizations are endorsing the concept.

The argument over managed competition does not center on the great "theological" questions of the debate... but on the politically decisive questions of how market forces are to be injected into the system.

Some Common Ground

Before entering on a critique of the managed competition reform option, I would like to share with you several key points where my colleagues at The Heritage Foundation and the proponents of managed competition are in substantial agreement.

First, in the diagnosis of the central disease afflicting the ailing American health care system, my Heritage colleagues agree with proponents of managed competition that Americans are not getting value for their money. This, to a large extent, is what we mean when we say that health care costs are too high; they are too high for what we are getting in return for our enormous expenditure of health care dollars.

Second, my Heritage Foundation colleagues also agree with proponents of managed competition that this disconnection between value and expenditures is directly attributable to the absence of market forces, particularly price competition.

Third, my Heritage colleagues and the proponents of managed competition agree that the current tax treatment of health care services contributes directly to this market failure, and that a change in the federal tax code is essential to weed out the inefficiencies of the system and broaden access to affordable health insurance for millions of Americans through the private sector. While we agree on the need to change the tax code, we differ on the specifics of the change. These structural differences, we believe, will have very different results both for the health insurance market and for the character of our health care delivery system.

Finally, we are in agreement on the threat to any future reform of the health care system posed either by global budgets or price controls, both of which will end up reducing the quality and quantity of medical services, and thus effectively denying medical services to the American people. Once again, if the budgets are meaningful, and if we are going to stand by them and directly limit health care spending in both the public and the private sectors, then at some point medical services are either going to have to be denied or in some way cut off. If we should embark on such a path, the American people will fully realize what hit them only after they recover from the initial shock of having a hospital or clinic door slammed in their faces, or in the face of a friend, relative, or loved one, because of a fixed national budget. Professor Enthoven has said it best: global budgets and price controls imposed at the national level are akin to "bombing from 35,000 feet"; from very high altitudes in your Washington office you do not see the people you are "killing."[4]

In a broader sense, our differences with proponents of managed competition are in the nature of a big family argument. Both advocates of consumer choice and advocates of managed competition are struggling to inject market forces as a curative into a health care system in which these forces are woefully deficient.

Having said that, I must tell you that we have grave misgivings. These misgivings do not center on the sincerity of the managed competition advocates of market-oriented reform. It is not so much about where they want to take us, but rather where we are likely to end up: in a government controlled, even more heavily regulated health care system, in which market forces not only are frustrated, but where costs, for a variety of reasons, are also likely to continue to increase. We fear that this effort will result in a health care system in which the net role of government is not less, but even more.

Professor Enthoven tells us that managed competition is not a free market, and he is right about that.[5] But there is no "theological debate" here over ideological straw men. Once again, nobody, from Adam Smith to Milton Friedman to my colleagues at The Heritage Foundation,

---

4 Quoted in *Health News Daily*, January 11, 1993, p. 2. For a detailed analysis of the likely impact of global budgets and price controls, see Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993.

5 Alain C. Enthoven, "Managed Competition in Health Care Financing and Delivery: History, Theory and

thinks that government should have no role at all in setting ground rules for the market, such as protecting consumers from fraud, monopoly, or collusive price fixing. No, the crucial issue is the degree of government management in managed competition—the structure and function of the formidable managed competition infrastructure itself. It appears to us to be an enormous administrative apparatus. Our contention is that the degree of management is large enough, and onerous enough, to smother the very market forces that advocates of managed competition are correctly trying to advance to fix the system, thus subverting the very object of their enterprise.

The Regulatory Issue

Right now government rules, regulations, and guidelines are adding to mountains of paperwork, driving up costs to consumers, hassling doctors and hospitals, and generally adding to the unnecessary complexity of the health care system. Medicare alone is governed by hundreds of pages of statutory law, plus over 1,000 pages in the Code of Federal Regulations, and over 22,000 pages of HCFA issuances and guidelines, a huge bulk of government paperwork that is growing each week. Added to the Medicare rules are the rules governing the ever-expanding Medicaid program, plus the huge new body of regulations covering doctors' laboratories under the Clinical Laboratories Improvement Act. And beyond that, doctors and hospitals, just like small businesses everywhere, now have to wrestle with new rules promulgated by OSHA, governing everything from the use of medical equipment and supplies to the disposal of medical wastes. You can point to any single regulation and deem it reasonable or of some benefit, even if of only marginal benefit to the public welfare. But taken as a whole this body of regulation is an enormous accumulation of red tape tying up America's health care delivery system. It has both direct and indirect costs on doctors and hospitals and clinics, costs in time and man-hours coping with compliance and its attendant paperwork, the transactional costs to the health care system. It would be a great public service if federal policy makers would quantify the total impact of government regulation on the costs of our health care system. I am certain that we would all be unpleasantly surprised at the price we are paying.

If you consider the current level of regulation, bureaucracy, and administration and all of their attendant costs—on doctors and patients alike—to be a serious problem in our health care system, then managed competition is not likely to relieve that problem. Rather, it likely to aggravate it. As Professor Enthoven himself has said, "Managed competition is not deregulation. It is new rules, not no rules."[6] He is right about that. And the new rule-making infrastructure, depending upon which incarnation of managed competition you are talking about, ranges anywhere from the merely big to the gargantuan.

The Bureaucracy Issue

For example, a common component of managed competition is a national health board, what my colleague Dr. Stuart Butler, a vice president of The Heritage Foundation, has dubbed the nation's new "Supreme Court of Health."[7] In Congressman Cooper's bill (H.R. 5936), this board

---

Practice," December 1, 1992 (revised January 13, 1993), p. 30. The paper was prepared for workshop sponsored by the Robert Wood Johnson Foundation, conducted by the Alpha Center in Washington D.C., January 7-8, 1993.

6 Enthoven, *op. cit.*, p. 30.

7 See Stuart M. Butler, "The Contradictions in the Clinton Health Plan," Heritage Foundation *Backgrounder* No. 924, January 12, 1993.

will consist of five members appointed by the President with the advice and consent of the Senate, and will sit for a term of seven years.

This kind of centralized government decision-making in health care is clearly incompatible with the promotion of flexibility, innovation, and pluralism that should characterize a market-oriented approach to resolving the health care crisis. It is a closing rather than an opening, of the system.

In virtually all of the versions of managed competition, the role of such a national health board would be formidable. For example, it would establish a uniform set of benefits, and thus set down on the federal level what specific benefits would be offered, and what will not be offered, by every accountable health plan, or federally qualified health plan nationwide. Tax benefits would be available only for federally qualified health care plans.

It would determine the range of legally authorized treatments for health conditions. Obviously, some treatments will not be federally authorized, receive no favorable tax treatment and thus, in some instances, depending on circumstance or geography, be effectively denied. Thus, while the national health board would not be in the business of making certain medical services illegal, it would still be in the business of promoting or limiting certain medical services.

The National Health Board will also set national standards of deductibles and cost sharing for insurance companies. Whether these deductibles or copayments are too high or too low will not be sorted out by the dynamism of the market. It is likely to be a political decision. And political decisions must always be popular. This means artificially low deductibles and copayments. Is it reasonable to expect otherwise? Is it reasonable to expect that a politically appointed body, answerable to the President and the Congress, will set economically rational deductibles and copayments? Consider our experience with Medicare.

Any national board, charged with making such far-reaching decisions, will, of course, require the collection of an immense body of data. Thus, in Congressman Cooper's bill, the national board will also create two other multi-million-dollar agencies: a five-member "health benefits and data standards board" to advise the National Health Board on such items as uniform benefits, auditing standards, and standards for collecting volumes of information from accountable health care plans. But its main function will be the advice on appropriate medical treatments, advice gained from consultation with Public Health Service.

The second agency created by the National Health Board in Congressman Cooper's bill is the "Health Plan Standards Board." This agency would make recommendations on standards for insurance plans, for health plan purchasing cooperatives, and risk adjustment factors for premium setting in the various states and localities around the country.

This kind of centralized government decision-making in health care is clearly incompatible with the promotion of flexibility, innovation, and pluralism that should characterize a market-oriented approach to resolving the health care crisis. It is a closing, rather than an opening, of the system. Parenthetically, I would call to your attention a survey conducted by the Gallup Organization for the Employee Benefits Research Institute on the question: who is in the best position to limit health care? Only 29 percent agreed that a national panel of medical professionals should have that authority. Only 20 percent agreed that a national panel of elected officials should have that authority. While the survey focuses on the question of rationing, it is nevertheless pertinent to the role of government as an agent for limiting services. The same sur-

vey revealed that seven out of ten were willing to allow limits on services by family doctors or local medical professionals.[8]

But the greatest exercise of authority reserved for the national health care board is that proposed by the Clinton Administration. In the Clinton incarnation of managed competition, the National Health Board would set a national budget for health care, governing both private and public spending and a national system of price controls governing health care goods and services —doctors, hospitals, clinics, prescription drugs, medical equipment, the works. Most managed competition proponents, including conservative Democrats and the representatives of the Jackson Hole Group, rightly and eloquently oppose such a concentration of central pricing authority. And the reason is obvious. If you assume, as do proponents of managed competition and other market-oriented reformers, that the absence of price competition is a central flaw in our health care system, then adding government price-fixing, eliminating the very possibility of price competition, is an absurdity.

In any case, the creation of a National Health Board with such broad powers compromises the very market-oriented policy that proponents of managed competition seek to realize. Even in the stripped down version proposed by conservative Democrats, this national health care board would constitute an enormous concentration of power, serving as the command and control center of the $840 billion health care system. One doesn't have to be a conservative Republican or a Jeffersonian Democrat to be concerned about this.

The Role of Purchasing Cooperatives

The second level of administration proposed by managed competition advocates rests with the health care purchasing cooperatives (HPPCs). These are geographically based organizations that will enroll the employees and collect the premiums for insurance and approve the various plans that may compete in any given geographic area. The health care purchasing cooperative is the central organization "managing" competition in the field.

In Professor Enthoven's original conception, the HPPCs are to function as non-profit membership corporations. The boards of these organizations will be elected by participating employers. This is conceived, once again, as a private sector institution. For free marketeers, this sounds good. But the functions of these institutions—at least as outlined by Professor Enthoven—are nevertheless considerable. They will: "monitor risks" among accountable health plans; provide information to employers and employees on the various plans; contract with employers and oversee the contracts; administer the health benefits contracts; serve as a general complaint desk for employers and employees on health benefits plans; interpret the contracts for employers and employees; resolve disputes with and among various health care plans; "stand behind" patients in disputes with health plans and presumably doctors and other providers; survey "consumer experience" with health insurance plans and build a data base; "in-

It seems to me that our future health care managers are going to have to have the managerial skills of a Lee Iaccoca and the selfless dedication of a Saint Francis of Assisi.

8 See John Immerwahr, "Health Care Rationing: A Public Perspective," a paper presented at a policy forum sponsored by the Employee Benefit Research Institute Education and Research Fund, Washington, D.C., December 1, 1992. See also John Immerwahr et al., *Faulty Diagnosis: Public Misconceptions About Health Care Reform*, a Report from the *Public Agenda Foundation*, 1992.

vestigate" consumer complaints and conduct scientific research into complaint areas and determine if there are any patterns of dissatisfaction, needing systemic reform or adjustment; prevent plans from getting into the system that do not meet federal criteria; drop existing plans for a variety of reasons, including "persistent noncooperation" with "risk adjustment or risk selection efforts" or "low market penetration."[9]

Now, this is a lot of work. Professor Enthoven argues that this new arrangement will be more efficient than current arrangements. Maybe.

But is this effort compatible with the establishment of a sound market? Needless to say, one of the key features of a sound market is the freedom of plans to enter and exit the market; the right to succeed and the right to fail. The proposed authority given to the HPPC to bar entry and to force out a plan that may in fact be competing and satisfying customers is a direct contradiction of the market. It constitutes an arbitrary limit on supply and a frustration of consumer demand. The danger is that the authority of the HPPC to determine who can and who cannot compete, beyond some basic ground rules that apply to all actual or potential competitors, will arbitrarily limit competition. The result: we could enfranchise an oligopoly. We could easily envision a situation where you would have a relatively small number of large insurance companies and HMOs dominating a market in any given geographical area, while smaller insurance companies, perhaps with more innovative health care delivery options for consumers, could be excluded. If supply is limited and demand remains constant or intensifies, the cost of health care is likely to go up and innovation is likely to be stifled. This is not a market-oriented outcome.

In carrying out their formidable array of responsibilities, Professor Enthoven advises us, HPPC officers are to act as "unbiased and honest brokers."[10] And perhaps they will. Perhaps this is all doable. But it is a big job, requiring uncommon mental and moral powers. It seems to me that our future health care managers are going to have to have the managerial skills of a Lee Iacocca and the selfless dedication of a Saint Francis of Assisi.

Obviously, if the HPPCs' functions are going to be carried out in an orderly fashion, they are going to have to have the force of law. They cannot be arbitrary. If there is any glitch in this process, what is the answer likely to be? A Milton Friedman-style free market reform? Not likely. Probably another layer of federal regulation. Your colleague Senator Nancy Kassebaum perhaps said it best, when she was quoted recently in *Health Care Reform Week*: the danger is that the HPPCs could very well become "little HCFAs"—a network of little bureaucracies all around the country, smothering the geographically based health insurance markets in a torrent of regulatory interventions.

Once again, recall that Professor Enthoven and his colleagues see the HPPCs as private nonprofit institutions, run by businessmen and governed by federal regulation. But in the incarnation of the Managed Competition Act (H.R. 5936), the HPPCs become state-sponsored organizations, with officers appointed by the governors of the states, in accordance with new state law, to manage the competition (Section 121).

This puts an entirely different cast on the character of the HPPCs. What would you have? In Maryland, you would now have the William Donald Schaefer HPPCs; in New Jersey, the Jim Florio HPPCs; in Virginia, the Doug Wilder HPPCs; in New York, the Mario Cuomo HPPCs, Republican-appointed HPPCs and Democratic-appointed HPPCs. With the very best of inten-

---

9 Enthoven, *op. cit.*, pp. 16-19.

10 *Ibid.*, p. 19.

tions, these institutions could not be free of politics nor their decisions free of political considerations.

Consider the possibilities. How will you ensure the integrity of the decisions governing entry and exit of competing health plans? Will you tighten the federal rules and regulations? Bring back HHS Inspector General Dick Kusserow? Send in the FBI? Set up a special oversight operations unit run out of HCFA? How do you prevent poorly performing plans with the good political connections from being retained in the artificially restricted market in the first place? How do you prevent good plans from being barred from competition, especially if they pose a threat to politically well-connected, well-financed competitors? We already have, as many of you know, a problem where big insurers and state regulators are on only the friendliest of terms. Who's in, who's out, who's up, who's down? In such an arrangement, these are not market questions; they become political questions. If Congress were ever to enact such an arrangement, Congress would have utterly politicized America's health care delivery system. Once again, I am not saying that this is the intention of the congressional proponents of managed competition, but I am saying that the infrastructure they propose to erect, plus the natural dynamics of our democratic political order, is likely to lead to such a result.

Professor Enthoven has said it best: "...competition is the way to achieve a system that is driven by the informed choices of consumers who are responsible for the cost consequences of their choices. A government controlled system is driven by political forces."[11] To that, I say amen.

Let me focus on two other troublesome areas.

A National Standard Benefits Package. Most managed competition advocates favor a proposal for a national standard benefits package. Superficially, this is a very attractive idea. Employers and employees will get tax breaks if and only if they purchase a government-approved standard package of benefits. Anything different from that, or above that, will not get any tax relief. If people should want unapproved benefits, fine, they may purchase such benefits, but such benefits are subject to a tax. In Title I of H.R. 5936, for example, there is a tax of 34 percent on the benefits of any health plan above the official level set in an "accountable health plan." If this means that these benefits are more expensive than otherwise, that's fine too. Both the tax code and the national standard will ensure more prudent purchasing.

The national benefits package is likely to grow; and once it grows, it is not likely to shrink. The federal legislative process is terrific at addition, and poor at subtraction.

In theory, this is attractive. In reality, this is a lobbyist's dream and a politician's nightmare. If you are a medical specialist, or a doctor who practices a particular type of medicine, it is financial death for you and your patients not to have your treatments or your specialty included in the national standard health benefits package. The political pressure to be included in any such standard benefits package will be enormous, with everything from chiropractic care to elective abortion jockeying for a slot. If you believe that this issue can be safely pushed off on a national health board, a political body created by the Congress and appointed by the President with your advice and consent, I respectfully suggest you are mistaken.

11 *Ibid.*, p. 25.

While managed competition proponents often favor the federal preemption of state mandated benefits, they risk replicating the same experience on the federal level.

Consider the experience of state legislatures. State legislators, as you know, have passed over 800 laws nationwide, requiring insurers to offer specific benefits—everything from mandatory chiropractic coverage (now required in 41 states) to such exotic requirements as *in vitro* fertilization, which is the law in Maryland. Some legislative mandates even include social services, such as psychologists and family counseling as part of health care packages.

The major economic effect of this state mandate process has been to drive up costs, and undermine the ability of small business to purchase basic and cost-effective health care plans. According to a report published by the National Federation of Independent Business Foundation, 44 percent of workers in companies now without health insurance coverage would have had some form of coverage if these state level mandates were eliminated.[12]

Unfortunately, the same process is bound to happen at the national level. Patient groups will gather, disease groups will be mobilizing, mainstream advocates will be jockeying for position along with various other alternative medicine specialties—everything from herbal medicine proponents to clinical psychologists, family counselors and chiropractors, acupuncturists and holistic medicine specialists. At some point, you can rest assured that the South Pacific medicine man will be parked on the Capitol steps.

You may think that your colleagues in Congress can exercise the necessary discipline to find the right mix of benefits and keep any standard benefits package reasonable or stripped down. I am not at all optimistic. The national benefits package is likely to grow; and once it grows, it is not likely to shrink. The federal legislative process is terrific at addition, and poor at subtraction.

Please consider our experience with Medicare Catastrophic Coverage Act of 1988. You may recall that former HHS Chief of Staff Tom Burke told Members of Congress and others that the Reagan Administration's Medicare catastrophic package, a sound and reasonable acute care hospitalization plan, was going to cost less than $6.00 a month, less than the cost of a carton of cigarettes. Dr. Otis Bowen, President Reagan's Secretary of HHS and my former boss, worked long and hard on that package, laboriously examining many different alternatives with the assistance of a terrific task force at HHS. Finally, he designed a modest addition to Medicare that would have brought peace of mind to millions of elderly Americans.

The rest is a painful recollection: We sent it to Congress. The House in particular expanded the bill way out of proportion to the original package. One benefit after another was added—including an expensive prescription drug benefit. In the House Energy and Commerce committee alone, there were nine different benefit additions. Additions were also made in the House Ways and Means Committee. What had started out as a modest expansion of hospitalization for catastrophic illness had become instead the most massive expansion of Medicare in its history. At the same time, there was confusion over costs. Dr. Bowen told Congress that he would recommend that the President veto a massive expansion, but the political pressure was to enact a bill providing catastrophic coverage for the elderly. After all, it was an election year.

Of course, one year later, especially after old folks were climbing on top of Dan Rostenkowski's car in Chicago, the greatly expanded Medicare Catastrophic Coverage Act, with its surplus premiums, was repealed.

---

12 Michael A. Morrisey, Ph.D. *Price Sensitivity in Health Care: Implications for Health Care Policy* (Washington, D.C.: NFIB Foundation, 1992), p. 5.

There is a better alternative to establishing a national standards benefits package, which tries to satisfy the greatest good for the greatest number as determined by a set of political, rather than market, decisions. Instead of setting a standard benefits package, set a basic benefits package and couple it with an individual, rather than an employer, mandate. In other words, establish a protective floor, a basic benefits package that is truly basic, including major medical, physicians' services, and catastrophic coverage. Then, allow for actuarial equivalents of such a package on the basis of cost, thus allowing companies to offer different types of benefits.

After establishing a basic benefits floor, then open up the system, giving tax relief directly to individuals and families who need to purchase more specialized services, including medical services out-of-pocket.

Forego any attempt to make one size fit all. Instead of trying to micromanage the process, establish an open consumer choice system. After establishing a basic benefits floor, then open up the system, giving tax relief directly to individuals and families who need to purchase more specialized services, including medical services out-of-pocket. Target tax relief, in the form of vouchers or refundable tax credits, based on need: the higher the family's health care costs, the larger that family's tax relief. In other words, lower-income families or families with higher health care costs would, under a consumer choice system, get more tax relief.

The Role of Employers. In the original managed competition concept and in the incarnations of managed competition proposed by President Clinton and the conservative Democrats, employers still play the dominant role. In the Clinton proposal, as vague as it is, all employers would either be required to give coverage to their employees or to enroll their employees in a managed care network.

Even in the conservative Democrats' proposal, while employers are not required to pay for coverage, we would have new legal obligations imposed on small businesses to join a HPPC, combined with stiff civil penalties if they don't. Under Section 105 of the Managed Competition Act, H.R. 5936, for example, every small employer is to have an agreement with the HPPC and also to offer coverage through the HPPC or face civil monetary penalties not to exceed $500 for each violation for each day on which the violation occurs. Attorney fees are to be awarded to employees who successfully complain about their boss's failure to sign up with the local HPPC.

At least from published reports, the Clinton Administration favors some sort of employer mandate. If House and Senate Democratic "play or pay" proposals were a bad idea because of the employer mandate, it is not clear why an employer mandate wrapped in the mantle of managed competition is any better. Objections to employer mandates are valid, it seems, in either case: mandates would result in job loss, a reduction in profits and productivity for American business in general and small business in particular, and result in higher prices for consumers and lower wages for workers. Higher prices and lower wages would likely result in any case because this is the only way that businesses will be able to compensate for the additional costs of mandated benefits.

Once again, why is it that a flat employer mandate embodied in managed competition, without even the option of a 7 percent payroll tax, is now considered a better idea? If the argument is that we can offset the new costs to small businesses with new tax breaks for employer provided insurance, even if we phase it in, then we should be clear how those new tax breaks are to be financed. A new payroll tax on workers?

It appears that when we in Washington tackle tough social and economic problems, such as health care, there seems to be a mental disconnect between our public policy prescriptions and the plight of small business. You may have seen George Will's column this morning in *The Washington Post*, where he cited the findings of your Republican colleagues on the Joint Economic Committee: Just since 1988, a combination of the 27 percent increase in the minimum wage and a raft of new regulations has resulted in a 33 percent increase in small business costs per worker.[13]

At the same time, we labor under a prejudice that our employers, including small employers, are somehow automatically responsible for the purchase of our health insurance, though they are not deemed especially competent to purchase any other type of insurance such as life insurance, auto insurance, or homeowner's insurance. And the tax code exclusively favors employer-based insurance. That is why people lose their health insurance when they lose their jobs. Of course, they do not lose any other type of insurance. It also explains why people are especially nervous about keeping their health insurance during these tough economic times, and why millions of Americans experience "job lock," the inability to change jobs for fear of losing their most important insurance, the health insurance that protects them and their families from serious illness and the financial devastation that accompanies serious illness.

While the conservative Democrats' proposal addresses the problem of access, under H.R. 5936, the place of work still determines the number and kind of plans—those approved by the HPPC—that are available to a worker and his family. In practice, this means that while a worker and his family will have access to insurance, if he changes jobs or loses his job, he would still have to change his health care plan. Unlike a consumer choice reform, there is no automatic portability.

Employer-based health insurance, with its exclusively favorable tax treatment, is, then, a kind of convenient national prejudice. And it is just that—a prejudice. It was born out of the price control regime of World War II, when the IRS created tax-free benefits for company-based health insurance to get around the government's comprehensive freeze on wages. This was a compensation decision, not a health care policy decision. Members of Congress should ask themselves the basic question: If we were to start afresh and design a fair, equitable and efficient health care system all over again, would we target tax relief to our people exclusively on the basis of where they happened to work, regardless of any other condition? If we are serious about fundamental reform, we must ask such fundamental questions.

In any case, if we take this prejudice to its logical conclusion as an instrument to secure universal access, then we have to address the broader economic impact of an employer mandate. What are the costs to small business of this mandate? How are these costs any different from the costs of the "play or pay" option backed by the Democratic congressional leadership several months ago? If "play or pay" was a bad idea then, why is this version better idea now? If it is better, then America's small business community ought to be told precisely why it is better.

Once again, we are not saying that the government should forswear establishing any ground rules for health insurance. Quite the opposite.[14] Our reservations on managed competition center on the nature and extent of those ground rules. Walter McClure, president of the Center for

---

13 George Will, "Get Ready for More Government," *The Washington Post*, February 25, 1993.

14 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*, August 14, 1992, and Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part IV: The Right Road to Health Insurance Reform" Heritage Foundation *Talking Points*, November 5, 1992.

Policy Studies and a leading health care policy expert from Senator Durenberger's home state of Minnesota, recently made a keen observation on the role of government in a sound market: "A market without government oversight is like a football game without a referee—a mere brawl in which the cheaters win."

Dr. Adam Smith, the author of the *Wealth of Nations* (1776) and the father of modern political economy, and free marketeers following him down the centuries have never advocated a brawl where cheaters win.

On the central point, we all agree: we need the referee. But the referee is not a player, and you never want the referee taking sides for or against the competing teams. Nor do you want the referee deciding who can and who cannot play the game, or who can or cannot be on the team. Surely, you do not want the referee deciding the appropriate number of forward passes or running plays in each game? Or the kind and number of plays?

Even the referee has to be kept in bounds. If you give the referee too much leeway to interfere in the game, he may not be averse to detailing the price, the size, and the color of the jerseys, or even the number of cleats on the players' shoes.

My colleagues at The Heritage Foundation want the referee to be a referee, who takes yardage away from the cheaters and kicks the dirty players out of the game. We don't think he should be calling the plays. Unfortunately, there is more management than competition in the leading incarnations of managed competition.