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Executive Summary

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BACK TO THE DRAWING BOARD: WHY TAX REFORM IS THE KEY TO HEALTH CARE REFORM

CARRIE J. GAVORA

After the passage of a spate of new federal benefit and regulatory requirements on health plans and the expansion of Medicaid through the new State Child Health Insurance Program (S-CHIP), House Speaker Newt Gingrich (R–GA) recently challenged Members of Congress to go back to the drawing board. In a conversation with the members of the health care task force he appointed last January to respond to efforts to regulate the health insurance market further, Speaker Gingrich asked them to develop a health care proposal that was positive, bold, and embraced "21st-century thinking." Encouragingly, there is growing sentiment among some Members of Congress and the public that consumer choice, rather than new regulation, should characterize America's health care delivery system.

One sign of this growing support is the number of recent proposals—from legislators as diverse as Senator Barbara Boxer (D–CA) and House Ways and Means Chairman Bill Archer (R–TX)—to allow individuals without employment-based health coverage to deduct all or a portion of their health insurance premiums from their annual tax bills. Senate Finance Committee chairman William Roth (R–DE) has indicated his intention to offer a similar amendment to the tobacco legislation under consideration by the full Senate. This deduction would give Americans far more choice by making it financially possible to enroll in non–employment based plans.

Obviously, positive and bold health care reform is necessary. Consider the problems plaguing the health care system: (1) Employer-based coverage erodes steadily; (2) employers pass increased health costs on to their employees more often; (3) the number of uninsured continues to grow; (4) consumers increasingly are becoming concerned about the "quality" of their health care; and (5) health care providers have become frustrated with bureaucratic controls.

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These problems can be linked directly or indirectly to one antagonist—the tax code. Because current law treats employer-purchased health coverage as a tax-free benefit for employees, a vast majority of Americans receive private health

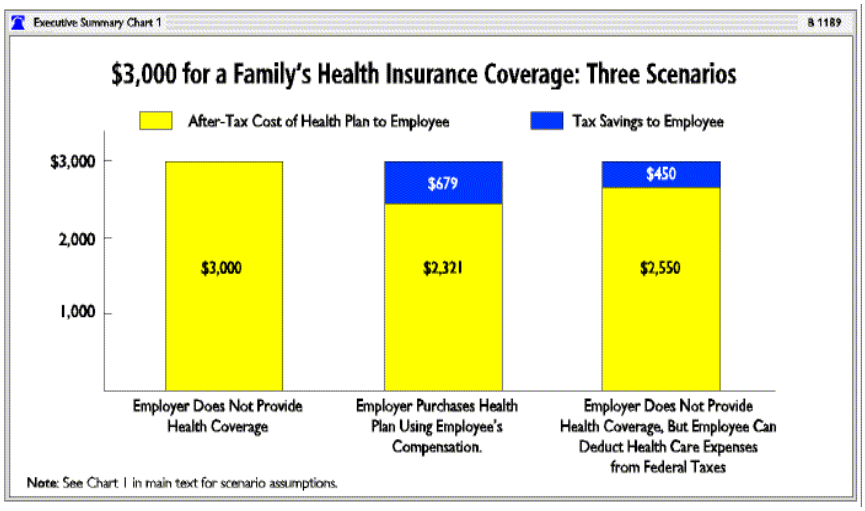
insurance coverage through their employers. Coverage obtained outside the place of employment normally is fully taxed. Such tax policy denies families offered employment-based insurance the ability to choose an alternative and own their health coverage. Current tax law also imposes a huge disadvantage on workers whose employers do not offer employment-based health coverage: They are unable to enjoy the advantages of purchasing health coverage through a larger group. And if they choose to purchase individual coverage for their family, they must do so with their after-tax, take-home pay.

If legislators are serious about enacting reforms to address these problems, they must combine meaningful tax reform with efforts to create a true marketplace for consumers. To that end, Congress should:

- Start leveling the playing field for families without employer-provided health coverage by allowing them to deduct the cost of health coverage they purchase on their own. The tax consequences of purchasing $3,000 worth of health insurance can vary, as Chart 1 illustrates.
- Give families the ability to choose from a variety of competing health plans, with different benefits at different prices. Consumers have few affordable options in the health care marketplace. To create a competitive market, less regulation—not more—is needed. Members of Congress, their families, and their staffs enjoy the benefits of a consumer choice health care market in the Federal Employees Health Benefit Plan (FEHBP). The FEHBP's success in holding down costs and maintaining consumer satisfaction is rooted in its simplicity. House Commerce Committee Chairman Thomas J. Bliley (R–VA) wants workers in private firms, particularly small businesses, to have choices similar to those that federal employees enjoy in the FEHBP. He has proposed "HealthMarts," voluntary purchasing cooperatives that would contract with a variety of different health plans preempted from state-mandated benefit laws, and that allow employees to choose from those plans based on price and benefit packages.

If the terms of the current health care debate continue to be defined by those who believe there are objective government-prescribed criteria for determining "quality," and that "consumer choice" means mandating certain benefits, then this debate will prove futile. Congress should not miss the opportunity to take up Speaker Gingrich's challenge and make bold and positive reforms of the health care system. Allowing individuals who lack access to employer-provided health coverage to deduct their health care costs from their income taxes and creating a more consumer-friendly health insurance marketplace is a good start.

—Carrie J. Gavora is Health Care Policy Analyst at The Heritage Foundation.



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What do legislators like Senator Barbara Boxer (D–CA) and Representative Bill Archer (R–TX) have in common? They are among the growing number in Congress who recognize, though to varying degrees, that tax reform is key to achieving significant health care reform. Both Senator Boxer and Representative Archer have offered proposals to provide tax deductions to individuals who purchase their own private health care insurance.[1] And although they seem to be unlikely allies, they represent the new and evolving bipartisan support in Congress for tax relief for individual purchasers of health insurance.

Today, millions of working Americans and their families who do not enjoy the benefit of tax-free, employer-provided health coverage must purchase coverage on their own in the individual market with their after-tax dollars. Many more go without health coverage because they simply cannot afford it. Depending on a family's state and federal income tax bracket, tax relief for workers with employment-based coverage can average between 15 percent and 40 percent of income taxes alone (and add an additional 7.65 percent for personal payroll taxes). One step toward bringing tax parity between those fortunate enough to have employer-provided health coverage and those who do not is to allow workers who, by virtue of their place of employment, cannot enjoy this tax relief to deduct their health expenses from their taxable income.

If legislators like Senator Boxer and Representative Archer can agree on the need for such tax relief, then individual deductibility for health costs would appear to be the legislative equivalent of a "sure thing." Sadly, however, the Senate Finance Committee missed an excellent

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1. Senator Boxer's bill, S. 1902, would allow individuals to deduct up to $2,000 each year in health insurance premiums. Representative Archer's proposal would allow employees who pay their own health care costs to take a deduction for the cost of health care insurance they purchase for themselves and for their families. See "Archer Seeks Input from Members on Health Related Tax Relief Proposals," Bureau of National Affairs *Heath Care Policy Report,* April 6, 1998, p. 572.

opportunity several weeks ago to move this winning issue forward. While acting expeditiously during the committee markup on the tobacco bill to raise taxes by approving a $1.50 per pack tax increase on cigarettes, lawmakers failed to pass this newly approved bounty to consumers in the form of health care tax relief. Committee chairman William Roth (R–DE) had proposed converting a portion of the revenue generated from the tax increase to health care tax deductions for individuals who do not have access to tax-free employer provided health care, and to accelerate the phase-in of current law that allows for 100 percent health care deductibility for the self-employed. Despite Senator Roth's best efforts, Senator Orrin Hatch (R–UT) made a motion to strike the health-related tax cuts from the bill. This motion carried by a vote of 12 to 7.

It is even more disappointing to note that, in place of providing tax fairness for individuals discriminated against by the current tax code, the committee approved the ill-advised legislation proposed by Senator Alfonse D'Amato (R–NY) that requires health plans to cover minimum hospital stays for mastectomies and lymph node dissection for the treatment of breast cancer. In short, costly mandates and yet more regulation trumped needed tax relief.

Recent polls have demonstrated a growing desire on the part of Americans to remedy the problems plaguing the health care system, including the growing number of uninsured working adults and dependents, the increased costs being passed to employees, and the lack of choice. There is burgeoning interest at the state and federal levels in creating competitive, consumer-based markets for private insurance, similar to what federal employees enjoy in the Federal Employees Health Benefits Plan (FEHBP). A variation of this idea, introduced by House Commerce Committee chairman Thomas J. Bliley (R–VA), involves the creation of "HealthMarts"—voluntary purchasing pools managed by a partnership of providers, insurers, employers, and consumers. This is a positive idea worthy of consideration in tandem with health-related tax reform.

Senator Roth has vowed to attach health-related tax measures to the tobacco legislation during consideration on the Senate floor. The inability of families without employer-sponsored coverage to claim a deduction while those with employment-based coverage receive tax-free benefits is indefensible and needs to be remedied. The full Senate should consider the merits of the Roth proposal carefully and challenge its opponents to defend the current discriminatory policy.

WHAT'S WRONG WITH TODAY'S TAX TREATMENT OF HEALTH CARE

Today's tax-favored treatment of employer-purchased health coverage distorts the market for health insurance by limiting tax relief to employer-purchased coverage. Furthermore, tax-favored employer-purchased health coverage is unquestionably discriminatory. If an employer does not provide health benefits, or does so for the worker but not for that worker's dependents, then the worker must purchase coverage with after-tax dollars (almost 80 percent of the uninsured are workers or dependents of a working head of household).[2] Allowing these individuals to deduct health care costs from their annual income taxes would be one way to level the playing field between employers and individual consumers. Moreover, it would give individuals the incentive to own and control their own health care policies, make coverage truly portable, and force health plans to be accountable to health care consumers, not employers.

Of course, health care tax deductions have a limited reach. They truly help only those who have taxable income. A better, but more costly, approach is to provide refundable health care tax credits to low-income taxpayers. For every dollar of health expenses that a worker deducts, what is saved in income taxes is equal to the marginal tax rate (of, say, 15, 28, or 31 percent). A tax credit,

2. "Sources of Health Insurance and Characteristics of the Uninsured," Employee Benefit Research Institute *Issue Brief* No. 179, November 1996.

however, is a dollar-for-dollar reduction in tax liability. Take, for example, a low-income couple with two children that earned $30,000 in 1997. With no deductions, the family's income tax liability was $1,879. If they had been allowed to deduct the premium costs for a $3,000 health plan, their tax burden would have been $1,429, a savings of $450. If the same $30,000-income family had been provided a tax credit worth 50 percent of the value of their health plan premiums, its tax burden would have been reduced by $1,500 for the year, and the family would have owed just $379.

Whether tax relief is provided through a tax deduction or a tax credit, such proposals are a step in the right direction and in keeping with the desire to use revenue generated by tobacco legislation or budget surplus funds for tax relief, rather than for new government spending programs. Furthermore, they offer Congress the opportunity to turn the tide of regulation and government mandates that dominate efforts to "reform" the health care system, and they offer families what they really want: Control and ownership of their health coverage.

Unfortunately, the response from the majority on the Senate Finance Committee has been to tax and regulate further.[3] This fact, combined with strong support for the oppressively regulatory H.R. 1415, the Patient Access to Responsible Care Act (PARCA) introduced by Representative Charles Norwood (R–GA) and the equally onerous alternative, H.R. 3605, the Patients' Bill of Rights Act introduced by Representative John Dingell (D–MI), means that the future does not bode well for supporters of market solutions to health coverage problems. Senators Alfonse D'Amato (R–NY) and Tom Daschle (D–SD) have introduced companion legislation to these bills in the Senate.[4]

Like many of the provisions in the PARCA bill that preceded it, the Patients' Bill of Rights Act requires, among other things, that health plans adopt a "prudent layperson" standard for coverage of emergency room visits, and provide a point-of-service (POS) option to beneficiaries. The bill dictates the terms and conditions of referrals to specialists and requires health plans to perform burdensome and costly health outcomes data assessment. It establishes strict guidelines for health plan utilization review efforts by requiring outside "experts" to review and approve a sampling of the health plans' utilization review criteria. The Patients' Bill of Rights Act also requires the President to establish a quasi-governmental health care quality advisory board to report on federally defined "quality" indicators. Finally, it allows individuals to sue their health plans in accordance with state laws to recover damages for personal injury or wrongful death.

Before lawmakers act on this or any other legislation, however, they first must ask: What are the problems they are trying to solve? And, once identified, would these proposals solve those problems?

PROBLEMS IN NEED OF A SOLUTION

Recent polls suggest that Americans generally are satisfied with their health care coverage, yet the sum of the problems plaguing the health care system has created the growing sentiment that changes still are necessary. The problems manifest themselves in five related ways.

1. Employer-based coverage erodes steadily, even though evidence suggests that more employers offer coverage. The number of people who receive health insurance through their place of work declined from 69 percent in 1987 to 64 percent in 1995.[5] Interestingly, a recent study found that more employers offer health coverage to their employees, with the number of employees who were offered

3. Senators Roth, Charles Grassley (R–IA), Alfonse D'Amato, Frank Murkowski (R–AK), Don Nickles (R–OK), Phil Gramm (R–TX), and Max Baucus (D–MT) opposed Senator Hatch's motion to strike the health care tax cuts.

4. The companion bill to H.R. 1415 is S. 644, sponsored by Senator D'Amato. The companion bill to H.R. 3605 is S. 1890, sponsored by Senator Daschle.

5. "Trends in Health Insurance Coverage," Employee Benefit Research Institute *Issue Brief* No. 185, May 1997.

coverage increasing from 72.4 percent to 75.4 percent since 1987. The number of employees taking insurance, however, declined from 88.3 percent to 80.1 percent. The study reported a variety of reasons, such as an increase in employee premiums and cost-sharing, declining real incomes, and Medicaid expansions.[6]

2. More employers pass increased health costs to their employees. According to a recent study performed by the Lewin Group for the American Federation of Labor–Congress of Industrial Organizations (AFL–CIO), the percentage of premiums paid by workers for self-only coverage increased from 10.2 percent in 1988 to 22 percent in 1996. For family coverage, employee contributions grew from 26 percent to 30.2 percent.[7]

3. The number of uninsured continues to grow. The Employee Benefit Research Institute (EBRI) in Washington, D.C., reports that, in 1996, 41.4 million non-elderly Americans (or 17.7 percent of the population) were without any form of public or private health coverage, up from 33.6 million (or 15.5 percent) in 1988. In 1996, 85 percent of the uninsured lived in families that were headed by workers.[8]

4. Consumers have become increasingly concerned about the "quality" of their health care, and they support efforts that claim to improve access and choice. A recent survey performed by the Henry J. Kaiser Family Foundation and Harvard University finds that 72 percent of respondents support passing the recommendations of the President's advisory commission on quality into law. This support declined dramatically, however—to 28 percent—when those surveyed were asked whether they would support the measure if it added $15 to $20 per month to their premiums.[9]

5. Health care providers have become frustrated with bureaucratic controls placed on the practice of medicine. It is estimated that more than 40 percent of doctors today are employees of hospitals, clinics, and managed care companies. Some physicians are joining a growing movement to unionize in order to gain bargaining leverage with managed care companies. For example, the United Food and Commercial Workers Union in New Jersey has petitioned the National Labor Relations Board to organize doctors in that state.[10] Others have suggested that managed care is driving doctors to retire early when their careers are reaching their peak.[11]

SOLUTIONS THAT DO NOT ADDRESS THE PROBLEM

The so-called patient protection bills before Congress would not solve these problems. Consider:

1. The erosion of employer-based health coverage; cost shifting to employees; and the growing number of uninsured.

It has been reported that, for every 1.0 percent increase in private health insurance premiums, approximately 400,000 people lose their health care coverage.[12] There are varying

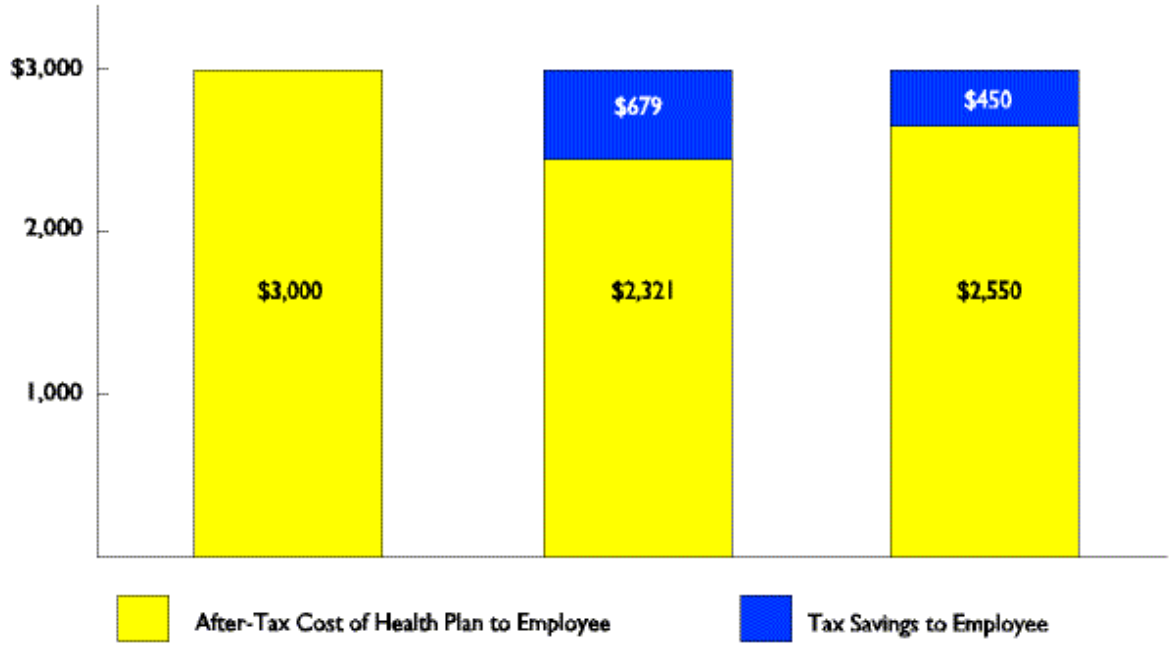
6. Philip Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment Based Health Insurance: 1987 and 1996," *Health Affairs* (November/December 1997).
7. John Sheils, Paul Hogan, and Nikolay Manolov, Ph.D., "Paying More and Losing Ground: How Employer Cost-Shifting Is Eroding Health Coverage of Working Families," prepared by the Lewin Group, Inc., for the AFL–CIO, 1998, p. 16.
8. "Sources of Health Insurance and Characteristics of the Uninsured," Employee Benefit Research Institute *Issue Brief* No. 192, December 1997, pp. 7, 15.
9. Press release, "Public Supports Broad Range of Proposals for Federal Consumer Protection in Managed Care, But Potential Consequences Raised by Critics Also Hit Home," Henry J. Kaiser Family Foundation, January 21, 1998.
10. John George, "NRLB Postpones Docs Unionizing Hearing," *Philadelphia Business Journal*, December 12, 1997.
11. Charles Krauthammer, "Driving the Best Doctors Away," *The Washington Post*, January 9, 1998, p. A21.

Chart 1 B 1189

$3,000 for a Family's Health Insurance Coverage: Three Scenarios

These scenarios are based on a family of four with annual gross income of $30,000.

	Scenario One: Employer does not provide employee health coverage.	Scenario Two: Employer purchases health plan using employee's compensation.	Scenario Three: Employer does not provide employee health coverage.
	Employee is able to choose coverage but must pay with after-tax income.	Employee does not have choice of health plan -- employer chooses health plan.	Employee is able to choose coverage and can deduct 100 percent of health care costs from income taxes.
Tax Savings to Employee	$0	$679	$450
Net Cost to Employee Due to Federal Taxes	$679	$0	$229



Note: Dollars spent by employers on employee health coverage are employees' wages diverted to health benefits and are income and payroll tax free to both employers and employees. We assume that when an employer does not provide health coverage, the family's gross income is increased by the amount of wages diverted to health coverage in scenario one — $3,000.

estimates of the costs of specific provisions in the Norwood/D'Amato bills and the Dingell/Daschle bills. A recent study performed by the Barents Group of KPMG Peat Marwick for the American Association of Health Plans reports the premium cost increases for certain

12. John Sheils of the Lewin Group, in a letter to Rick Smith, American Association of Health Plans, November 17, 1997.

provisions as follows: 2.7 percent to 8.6 percent for exposing health plans to liability; 2.2 percent to 6.9 percent for defining health plan utilization review as part of the practice of medicine; and 4.1 percent to 6.1 percent for limiting a health plan's ability to determine medical necessity.[13] Another study performed by Coopers & Lybrand for the Kaiser Family Foundation reports the following premium impact of certain provisions of the PARCA bill: 0.11 percent for requiring coverage for emergency services; 0.08 percent for third-party appeals of health plan decisions; and 0.23 percent for mandatory POS requirements.[14]

These studies and their findings are interesting for two reasons. First, the studies look at different provisions in the two bills. Therefore, an apples-to-apples comparison of the findings cannot be made. In fact, the Kaiser Foundation study indicates it was unable to estimate the cost impact of the liability provision contained in the Norwood/D'Amato bills. Exposing health plans and possibly employers to liability for bad health outcomes is arguably the most costly, and therefore most controversial, element of these bills. Second, the Kaiser Foundation study notes that, in a number of the provisions studied, such as third-party appeals, coverage of emergency services, and direct access to specialists, the low cost estimates are due in part to the fact that many health plans already are voluntarily complying with these provisions. This leads one to question the reason that some in Congress feel the need to mandate them at all.

Even if some inaccuracies in these studies are accepted, it should be clear that any time the government mandates new benefits, or places restrictions on methods insurers use to rein in costs, coverage will become more expensive. The Congressional Budget Office and the General Accounting Office (GAO) have documented the impact that costs have on the provision of insurance and on employers' decisions either to restrict certain types of benefits (spawning new cries to mandate that those now-restricted benefits be covered) or to drop coverage altogether. In that employers hold almost all the cards in the private health care system today, their decision either to cut back or to withhold coverage as a result of cost increases has an obvious and significant impact on individual consumers of health care. The U.S. Chamber of Commerce recently reported that 46 percent of small employers say they are "very likely" or "somewhat likely" to stop providing health coverage if premiums increase by as much as 20 percent.[15]

States have strangled the private health insurance market for years with red tape and regulation in the form of benefit and provider mandates. In 1997, there were a total of 1,062 such mandates nationwide—86 more than in 1996. In addition, there were 154 laws regulating managed care practices at the state level in 1997.[16] In 1996, the GAO reported that mandated benefit and provider laws accounted for 12 percent of the cost of claims in Virginia and 22 percent in Maryland.[17] The Minnesota Council of Health Plans conducted a survey of health care finance experts and company chief

13. Press release, "New Study Shows Devastating Impact of Proposed Health Care Mandates on American Families, Workers and Business Nationwide," American Association of Health Plans, April 27, 1998.

14. "Estimated Costs of Selected Consumer Protection Proposals," Henry J. Kaiser Family Foundation, April 1998.

15. Press release, "Majority of Small Employers Likely to Drop Health Coverage If Congress Exposes Them to Lawsuits, New Survey Shows," Health Benefits Coalition, survey conducted by Public Opinion Strategies for the U.S. Chamber of Commerce, February 24, 1998.

16. Blue Cross/Blue Shield, *1997 Annual Survey of Plans.*

17. U.S. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS 96–161, August 19, 1996.

executives to learn the reasons that health costs were increasing in Minnesota. Among the reasons cited were federal and state mandates. It is estimated that

> up to 25 percent of the costs of premiums paid by buyers of taxable health plans is due to state taxes and state-mandated coverage requirements.[18]

At the same time that employment-based coverage erodes, state governments and Congress have passed laws that almost guarantee there will not be a viable individual health care market to which the uninsured can turn. Workers who are forced to seek coverage in the individual market soon realize there is virtually no market at all. The GAO recently reported that, as a result of the guaranteed issue requirement (to offer health insurance to anyone who applies) in the individual market included in the Kennedy–Kassebaum Health Insurance Portability and Accountability Act, many consumers who lost group coverage are forced to pay significantly higher rates for individual coverage, with rate increases ranging from 140 percent to 600 percent.[19]

At the state level, laws combining guaranteed issue with community rating (which prohibits insurers from charging different premiums for different groups within a geographic area) have had a disastrous impact on the individual health care market. For example, Kentucky passed comprehensive health reforms in 1994 that included guaranteed issue and community rating. Premium costs increased significantly in the individual market, causing 45 private insurers to stop selling policies in that state. The state legislature and Governor Paul Patton (D) were forced to repeal some of the 1994 reforms, allowing insurers once again to base premium charges, to a limited degree, on a person's health. In addition to this change, the state passed a state health care tax deduction for the self-employed and those who do not have employer-sponsored insurance. Kentucky's experience prompted Governor Patton to label the state's experiment with this type of market regulation a "noble failure."[20]

To make matters worse, by limiting the tax relief individuals can receive for out-of-pocket health expenditures, Congress stripped away the one benefit that made the individual market more appealing to the uninsured. In the early 1980s, tax filers who itemized their deductions could claim a deduction for out-of-pocket health expenses that were more than 3 percent of their adjusted gross income (AGI). Over the years, Congress raised this threshold to the current level of 7.5 percent of AGI. This, combined with state-mandated benefits and rating restrictions, has had a real impact on participation in the individual market. It is estimated that approximately 36.1 million people purchased individual coverage in 1978 prior to Congress's raising the deductibility threshold. Today, approximately 13 million people have individual coverage.[21] According to testimony in April 1998 before the House Ways and Means Oversight Subcommittee, this

18. P.R. Newswire, "Annual Health Plan Reports Show Rising Medical Costs and Utilization Are Driving Premium Increases and Narrowing Margins," April 1, 1998.

19. U.S. General Accounting Office, *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, and Regulators,* GAO/HEHS 98–67, February 1998, p. 2.

20. "Lawmakers Send Governor Legislation to Scale Back Reforms, Set Up Kid Coverage," Bureau of National Affairs *Health Care Policy Report,* Vol. 6, No. 14 (April 6, 1998). See also Rachel McCubbin, "The Kentucky Health Care Experiment: How 'Managed Competition' Clamps Down on Choice and Competition," Heritage Foundation *Backgrounder* No. 1119, June 6, 1997.

21. Information included in testimony of William Gradison, past president of the Health Insurance Association of America, "Health Insurance Tax Laws," before the Hearing of the Oversight Committee, Ways and Means Committee, U.S. House of Representatives, 105th Cong., 2nd Sess., April 23, 1998.

fact is buttressed by data from the EBRI, which suggests that tax incentives are key to whether individuals will seek health coverage for themselves and their families. Individuals who must pay for health coverage with their own after-tax dollars are 24 times as likely to be uninsured than those with employer-provided coverage.[22]

2. Increasing consumer concerns about health care "quality" and the desire for choice and access; and provider frustration with bureaucratic interference with the practice of medicine.

A study performed by the Commonwealth Foundation aptly points out that consumer satisfaction with health care is tied directly to consumer choice of health plan (even more than choice of physician).[23] Considering this fact, should the proper policy response be to force all employers to offer a choice of plans to their employees? Under the current employer-based system, that would appear to be the only way to make sure choice exists and is, in fact, what both the Dingell/Daschle and Norwood/D'Amato bills would do by requiring health plans to include a mandatory POS option for enrollees. But this response by lawmakers misses the mark by ignoring the first half of the consumer choice paradigm: The consumer.

Given the option, consumers may make entirely different determinations than their employers or federal lawmakers about the type of benefits they want, and the degree of freedom to choose a doctor they desire, by weighing considerations of costs and individual needs. Millions of federal workers and retirees make these types of decisions every year in the FEHBP. These choices about tradeoffs (more benefits or a cheaper health plan) only become meaningful to the consumer when the consumer makes the decision. Often, the frustration with the managed care model is that someone other than the consumer or the consumer's doctor makes the cost/benefit tradeoff decision. The same is true when the government steps in to "protect" patients and providers—arbitrary and blanket decisions are made about what is important to consumers (although the government pays less attention to the costs of those decisions because they are passed to employers and, therefore, employees in the form of lower wages and/or higher cost health care).

The so-called patient protection bills before Congress only substitute the decision-making of private-sector bureaucrats with that of government bureaucrats. A key difference is that there is a degree of flexibility in the private sector for health plans to change policies in response to employer demands and media scrutiny. Decisions made by lawmakers become law and therefore require an act of Congress to change. In both cases, however, third parties and special interests that do not necessarily represent the interest of the consumer mute accountability to the consumer for those decisions.

The level of frustration among providers with the bureaucratic interference in the doctor–patient relationship is reflected in the American Medical Association's recent endorsement of the Dingell/Daschle bills, even though this measure poses a threat to the limited degree of provider autonomy that the current system affords doctors. According to the Blue Cross/Blue Shield Association, a seemingly innocuous provision requiring the collection of standardized plan data on quality indicators and health outcomes would have the adverse effect of requiring all forms of managed care to operate more like health maintenance organizations (HMOs).

HMOs routinely collect patient data to aid them in better managing patient care, and they often have information systems in place that make these efforts less burdensome. Managed

22. *Ibid.* Gradison cites EBRI data.

23. Karen Davis et al., "Choice Matters: Enrollees' Views of Their Health Plans," *Health Affairs* (Summer 1995), pp. 99–112.

care products like preferred provider organizations (PPOs) are less "managed" by the insurer in that they offer open access to providers and minimum, if any, care coordination by primary care "gatekeepers." In the case of PPOs, the level of data collection and case management necessary to measure health outcomes would be exceedingly difficult and would force insurers to rewrite contracts with their affiliated providers to require them to meet these new demands. According to Blue Cross/Blue Shield,

> the "one size" data reporting, quality assessment and clinical performance standards under consideration were not designed for open-access products like PPOs. Open-access products would need to change their structures fundamentally to become more "managed" under gate-keeper physicians to comply with some of the proposed standardized quality requirements.[24]

Disturbingly, Congress already has instructed the Health Care Financing Administration to require health plans contracting with the new "Medicare + Choice" program to report such data to the government.

A CONSUMER CHOICE ALTERNATIVE

If the terms of the current health care debate continue to be defined by those who believe there are some objective government-prescribed criteria for determining "quality" and that "consumer choice" means mandating that health plans cover certain benefits, then this debate will be futile. And the American people will be the losers. Benefits will be added, costs will increase, and health care consumers will realize little, if any, real benefit from these changes. In addition, they are likely to remain trapped in the same health plan they did not like in the first place.

The consumer choice paradigm envisions an engaged consumer, armed with information and purchasing power, that drives the health coverage decisions in a competitive marketplace. This model of individual choice offers consumers something radically different from legislated or regulated choice; this is the type of choice Americans seem to want. A recent survey performed by the Charlton Research Company finds that, although a majority of Americans feel certain things need to be changed in the health care system, two-thirds of survey respondents think health care is regulated enough already. The survey finds that cost and lack of choice still are the issues most concerning Americans about their health care: 60 percent of respondents cite cost as their primary or second-greatest concern; 35 percent cite lack of choice of health plans. (Compare this with 32 percent and 29 percent, respectively, for the issues of restriction on choice of doctors and "patient rights.")[25]

Fixing the Affordability Problem

Tax reforms address the affordability problem that consumers have identified. Such reforms are necessary to correct the bias in the tax code against individual control and ownership of health coverage. Giving families a tax credit or an income tax deduction for health care expenses is one way to make health care more affordable. Tax credits and deductions are more effective if they can be used for recognized health care expenses, as opposed to just insurance premiums. If out-of-pocket expenses were deductible, for example, families would be encouraged to seek higher-deductible insurance plans that provide catastrophic protection and to spend out-of-pocket dollars for routine health coverage. This would give families a broader choice of doctors while protecting them from becoming impoverished by a costly illness.

Refundable tax credits are better than deductions as a means of getting resources into the hands of the families that need them. Uninsured

24. Blue Cross/Blue Shield Association, Medical Management Policy Statement, April 30, 1998, p. 2.

25. Charlton Research Company, "Health Care Reform, Executive Summary," Public Opinion Study commissioned by the Congressional Institute, Winter 1998.

families at very low incomes will receive little, if any, value from a deduction because they have little taxable income. Credits that are taken off the top of a family's tax liability and are refundable to those whose credit exceeds their tax liability are much more valuable.

Addressing the Choice Problem

Pursuing policies that create a more effective individual and group market for health plans would address the choice problem consumers have identified. Obviously, tax policies that level the playing field between individually and employer-purchased health coverage, and that free up resources for families to use for health coverage, necessarily give people more choice. But, as noted above, there are severe regulatory burdens on the health insurance market today that offer little opportunity for families to purchase coverage on their own.

One consumer choice model that is surprisingly free of much of the regulation adversely affecting the private insurance marketplace is the government's FEHBP program. The FEHBP does not require participating health plans to offer a government-set standardized benefits package, and it exempts plans from state-mandated benefit laws. Participating health plans must cover only specified services, such as inpatient and outpatient care. With a defined contribution from the government, health plans are able to compete for federal employees' business based on both costs and benefits covered.

Encouragingly, there seems to be growing sentiment among some Members of Congress and the public that some combination of tax relief and insurance deregulation is needed. One sign that this is occurring is the proposal by Senator Roth to allow individuals without employment-based health coverage to deduct their health insurance premiums and to accelerate the phase-in of current law to allow 100 percent deductibility for the self-employed. This proposal represents an incremental step toward more consumer empowerment in health care decision-making.

Another sign that Congress may be moving in the right direction is the percolating interest in a proposal put forth recently by Representative Bliley concerning the creation of HealthMarts—voluntary purchasing cooperatives that would answer the consumer's question, "Where do I go to purchase coverage?" The concept is to allow providers, insurers, employers, and consumers to band together to form purchasing pools, contract with multiple insurers, and receive the benefits of preemption from state-mandated benefit laws. Small employers can enjoy the benefits of pooling risk, while their employees can enjoy the choice and affordability that competing health plans offer. More important, much like Members of Congress who do not like their current health plan in the FEHBP, during an open season employees could choose a different plan that better meets their needs.

Representative Bliley points out that, under Section 106 of the tax code governing the tax treatment of health care insurance, the exclusion for the cost of health coverage applies if the employer pays directly for health insurance premiums or if he contributes to a "separate trust or fund" for his employees.[26] This gives employers the ability to place their employees in a purchasing cooperative like a HealthMart without losing the tax benefit; that is, employers essentially could "voucherize" their employee's health coverage, giving them wider choice of health plans.

The HealthMart proposal, as it stands now, has some limitations. It is designed only to allow employer groups of two or more to participate; therefore, it would not be of benefit for individuals looking for a health coverage market if they are allowed to deduct the cost of their health care purchases. Some criticize the idea because it provides yet another new target for government regulation. But HealthMarts are designed to escape onerous regulation and would not function if they became

26. United States Code of Federal Regulations, "Contributions by Employer to Accident and Health Plans," Title 26, "Internal Revenue," Chapter 1, Section 1.106–1.

laden with burdensome mandates. A final limitation is that the decision to join a HealthMart and the choice of which HealthMart to join is left to the employer, not the employee.

This latter criticism gets to the fundamental need to put purchasing decisions under consumers' control. Again, this cannot be achieved without tax reform. Ultimately, HealthMarts may serve as a positive vehicle for eliminating the tax-favored status that employer-purchased coverage now enjoys and replacing it with a broad-based refundable tax credit. Consumers who come to see the value in exercising individual choice in a competitive system eventually may come to question the need for having their employers involved in their health coverage decisions altogether.

CONCLUSION

Members of Congress should not miss the opportunity presented to them by a challenge recently made by House Speaker Newt Gingrich (R–GA). Following the spate of additional federal benefit and regulatory requirements on health plans and the expansion of Medicaid in the new State Child Health Insurance Program (S–CHIP), Speaker Gingrich asked lawmakers to go back to the drawing board to develop "bold" and "positive" reforms of the health care system.[27] They can start by allowing individuals who lack access to employer-provided health coverage to deduct health care costs from their income taxes and by creating a more consumer-friendly health insurance marketplace. If Senator Boxer and Representative Archer can agree on consumer choice, then these reforms must be something worth implementing.

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27. David Nather, Bud Newman, and Cheryl Bolen, "Gingrich Tells GOP Health Care Group to Start Over, Produce 'Bolder' Proposal," Bureau of National Affairs *Health Care Policy Report,* Vol. 6, No. 21 (May 25, 1998), p. 860.