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Rising Costs, Reduced Access: How Regulation Harms Health Consumers and the Uninsured

Grace-Marie Arnett

Members of Congress once again are embroiled in a debate over managed care reform legislation that attempts to address some of the symptoms plaguing America's health care system. Instead of changing federal policies that restrict competition and patient choice, the Patients' Bill of Rights Act of 1999 would burden the health care system with more federal regulation. A growing body of evidence indicates that adding new layers of regulation would increase the cost of health insurance for many Americans and add to the number of people who are uninsured. Specifically:

- **The managed care reform proposals would increase health insurance costs for America's workers and their families.** According to recent Congressional Budget Office (CBO) estimates, if the Patients' Bill of Rights Act of 1999 provisions were fully phased in, insurance premiums would rise by an average of 4.8 percent. The private-sector mandates in Title I of the bill would cost about $3 billion in 2000 and $13 billion in 2004.
- **In driving up the cost of coverage, the proposed legislative reforms would throw more people off the insurance rolls.** The CBO, as well as several private economists, estimates that each 1.0 percentage point increase in the cost of health insurance drives between 200,000 and 300,000 additional Americans off the insurance rolls.

Each new mandate and regulation passed by federal and state regulators may increase costs by a percentage point or two; some by much more. And even though they can be justified individually, the cumulative effect of the added regulations is that more and more people will be forced to forego health coverage.

In a properly functioning health care market, in which consumers could choose and own their health insurance policies, companies would be

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forced to shape insurance products to meet customers' needs for services, quality, and price. Companies that did not do so quickly would lose customers and revenue. Sellers of health insurance policies would be bound by the contract agreement they had made, which would be enforceable through the existing legal system.

The direct link between imposing regulations and mandates on the health insurance market and the number of uninsured is well-established in the research. For example:

- Duke University researchers found that the higher the number of coverage requirements placed on plans, the higher the probability that an individual will become uninsured and the lower the probability that a person will have any private health insurance coverage, including group coverage.
- Professors at Wayne State University and the University of Alabama–Birmingham determined that as many as one in four Americans lacks health insurance because of benefit mandates. Each additional mandate significantly lowers the probability that a firm or an individual will have health insurance.
- A researcher at Georgia State University found that state guaranteed issue requirements, coupled with either community rating or rate bands in the small-group insurance market, increase the probability that a person will become uninsured by nearly 29 percent.

As costs and the number of uninsured continue to rise, a different approach clearly is needed. By injecting patient choice and competition into the health care sector, many of the problems the political community is attempting to solve through legislation and regulation would be addressed by consumers within a competitive marketplace.

Specifically, Congress should consider:

1. **Targeted tax credits for the uninsured.** Legislators on both sides of the political aisle are introducing a number of innovative tax credit bills. Other bills would allow individual tax deductions for the purchase of health insurance. Tax deductions can ease the burdens of self-employed individuals, but they do not roll back the regressive nature of the current system, which provides more tax relief for those with higher incomes and a higher tax break for the purchase of more expensive health insurance policies. Tax credits would be more equitable, and they could be made refundable and targeted to those who are most likely to be uninsured. Tax credits would empower consumers to shape the health insurance market through competition instead of regulation.
2. **Alternative purchasing mechanisms.** Providing alternative grouping mechanisms for individuals in purchasing health insurance would give them the benefits of group purchasing. A number of mechanisms are being debated, like voluntary choice cooperatives, HealthMarts, and association health plans.
3. **A moratorium on regulation and mandates.** Congress and state legislators should place a moratorium on passing more insurance regulations and health benefits mandates until their costs and impact can be explored in full. People are denied health coverage suited to their needs when government forces plans to provide an array of benefits designed by politicians, not consumers. Regulations and mandates drive up health care costs, making insurance more costly for individuals and families who have no choice but to purchase the policies prescribed by politicians.

If increasing access and lowering costs are genuine goals of Congress, a better approach would be to empower individuals and families to make their own health care choices, restore the doctor–patient relationship and the independence and integrity of the medical profession, and force the health care industry and insurance companies to compete for consumer dollars. The health care delivery system, at all levels, should be directly accountable to those it serves.

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RISING COSTS, REDUCED ACCESS: HOW REGULATION HARMS HEALTH CONSUMERS AND THE UNINSURED

GRACE-MARIE ARNETT

Members of Congress once again are embroiled in a debate over managed care reform legislation that attempts to address some of the symptoms plaguing America's health care system rather than the underlying causes of its disorders. Instead of changing federal policies that restrict competition and patient choice, the Patients' Bill of Rights Act of 1999 would burden the health care sector with even more federal regulation. And a growing body of evidence indicates that adding new layers of regulation will (1) increase the cost of health insurance for many Americans and (2) add to the number of people who are uninsured.

Today, nearly 44 million people will go without health insurance at some point during the year; this number continues to grow at the astonishing rate of 100,000 each month.[1] The proposals in the managed care reform legislation before Congress—despite being called a "patients' bill of rights"—would allow politicians, not patients, to decide what procedures and medications health insurance policies would cover and restrict, and would do little to expand choice and access to affordable coverage. Specifically:

- **Managed care reform proposals would increase health insurance costs for America's workers and their families.** According to recent Congressional Budget Office (CBO) estimates,[2] if the provisions of the Patients' Bill of Rights Act of 1999 were fully phased in, insurance premiums would rise by an average of 4.8 percent. The private-sector mandates in Title I of the bill would cost about $3

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1. Dick Armey and Pete Stark, "Medical Coverage for All," *The Washington Post,* June 18, 1999.
2. Congressional Budget Office, "S.6 Patients' Bill of Rights Act of 1999, as Modified by the Sponsors," cost estimate, June 16, 1999.

billion in 2000 and about $13 billion in 2004. The costs in 2004 would represent about 3.4 percent of total private-sector health insurance expenditures.

- **In driving up the cost of coverage, the proposed legislative reforms also would throw more people off insurance rolls.** The CBO, as well as several private economists, estimates that each 1.0 percentage point increase in the cost of health insurance drives 200,000 to 300,000 additional Americans off the insurance rolls.[3]

The imposition of regulation, without considering cost or consequence, is not unlike the 18th century practice of "bleeding" patients to drain off mysterious "humours." Increasingly, empirical evidence shows that legislative cuts into the normal functioning of a health care market—a practice that has accelerated in recent years following the enactment of numerous state regulations, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the Balanced Budget Act of 1997—have the same debilitating effect on consumer choice and competition as the primitive medicine practiced by physicians 200 years ago. Today's politicians, in directing the practice of medicine, may feel they are doing something to help, but, ultimately, patients are the ones who suffer.

THE HIGH COST OF GOOD INTENTIONS

The data show that well-intended health care legislation enacted during the past 10 years has done little to improve the prospect of providing adequate health care for all Americans. In 1987, 32 million Americans under age 65 went without health insurance at some point during the year, or 14.8 percent of the population. A decade later, the number had risen to nearly 44 million uninsured—or 18.3 percent of the population under age 65.[4] Instead of attending to the needs of the millions of Americans who lack health insurance, Congress and the White House now argue over legislation that addresses the legitimate concerns of a relatively small percentage of people with health insurance who are unhappy with it.

The fact that most Americans are satisfied with their health coverage is lost in the shuffle. In October 1998, Roper Starch Worldwide reported that only 7 percent of Americans polled were "not at all satisfied" with their health plan. In late January and early February 1999, 88 percent of Americans polled by ICR/Associated Press expressed satisfaction with the quality of their health insurance coverage. A survey by Princeton Survey Research Associates in late 1998 showed only 23 percent of Americans polled believed that patient protection legislation should be the top priority of the health care debate in Washington, D.C.[5] A 1998 poll by Charlton Research Company found that 66 percent of respondents said health care is regulated enough already. Only 25 percent said more regulation is needed, but the majority of these people changed their minds when they learned regulations would increase government bureaucracy or health care costs.[6]

Instead of arguing over new mandates for a relatively small number of Americans, Congress should focus on the root causes of the health care problems facing America—the growing burden of regulation on the health care industry, which is increasing the cost of health insurance and swelling the ranks of the uninsured. The health industry is perhaps the most heavily regulated sector of the U.S. economy. Most Americans recognize that regulation of an industry drives up prices, restricts innovation, dries up competition, and forces busi-

3. Congressional Budget Office, "CBO's Estimate of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103," May 13, 1996; and John Sheils, Vice-President, the Lewin Group, Testimony before the Subcommittee on Health, Committee on Ways and Means, 106th Cong., 1st Sess., June 15, 1999.
4. U.S. Bureau of the Census, *Current Population Survey,* March 1998.
5. Karlyn Bowman, "Americans Satisfied with Health Care if Costs Stay Down," *Roll Call,* February 25, 1999, p. 14.
6. Charlton Research Company, poll conducted for the Congressional Institute, January 1998.

nesses to cater to regulators, not consumers. This clearly is the case in the health care sector. Each new mandate and regulation passed at the federal and state level may increase costs by a percentage point or two, or by much more. And even though each regulation or benefit mandate can be justified individually, often by a constituency that argues passionately for its merits, the cumulative effect of adding more regulation is that more and more people are forced to forego health coverage.

The problem of over-regulation is exacerbated by the fact that patients do not control either their money or their choices in obtaining health care and medical coverage. For the vast majority of insured Americans, health services and insurance products are purchased *for* them by private- or public-sector bureaucracies. The majority of Americans who receive their health insurance through their workplace is offered only one health insurance plan. These Americans do not have the opportunity to choose medical services or coverage that best suits their individual or family needs and cannot play the balancing role of consumers in forcing diversity and price competition in the health care market. Doctors, care providers, and patients alike find themselves on the receiving end of decisions made by third and fourth parties, including employers, managed care network bureaucrats, and, increasingly, government officials.

The solution to consumer dissatisfaction with their health plans is to give consumers greater flexibility to choose the benefits and plans that satisfy their needs. Consumers who were able to exercise their power in the health marketplace and select from among competing health plans would have much less need to march to Capitol Hill for an act of Congress to protect them whenever they were unhappy with their health plans. Instead, they could vote with their feet and move to another plan.[7] In a properly functioning health market, in which consumers could choose and own their health insurance policies, companies would be forced to shape insurance products to meet their needs for services, quality, and price. Companies that did not do so quickly would lose customers and revenue. Sellers of health insurance policies would be bound by the contract agreements they had made, which would be enforceable through the existing legal system.

The way to achieve a consumer-driven market for health insurance is to change federal tax policy so that individuals can select and choose their own health coverage arrangements and obtain direct tax relief when they do so. Congress could begin the process by giving uninsured Americans tax credits to purchase their own health care coverage while lifting regulatory barriers to a properly functioning health insurance market with alternative purchasing mechanisms. Congress should place a moratorium on mandates and regulation until their costs and impact are examined in full. Taxpayers could facilitate the process by holding federal and state officials and bureaucrats accountable for the consequences of their policies. In the meantime, the rule that governs the practice of medicine also should govern efforts to reform health care: First, do no harm.

WHY THE UNINSURED ROLLS ARE GROWING

For decades, policymakers at all levels of government have searched for ways to help families to gain greater access to affordable health care. At the state level, legislators have imposed thousands of new rules and regulations with the intent of forcing health insurers to offer coverage with good benefits at reasonable costs and with protections for the policyholders. Additional insurance regulations and benefit mandates were passed at the federal level with much the same intent. Yet, despite these efforts and a sustained period of economic growth, the number of Americans without health insurance continues to rise—reaching nearly 44 million today.[8]

7. In the established Federal Employees Health Benefits Program, the Office of Personnel Management reports that only 5 percent of participants switch plans during the annual open enrollment session.

Who Are the Uninsured?

The uninsured are disproportionately young, minority, lower-income Americans who work for small companies or are their dependents.[9] Hispanics and minorities are the most likely to be uninsured: Among working-age Americans, 14 percent of whites, 24 percent of blacks, and 38 percent of Hispanics are uninsured.[10] The numbers of uninsured are even higher for lower-income minority group members, reaching 52 percent for Hispanic families whose incomes fall below the federal poverty level.

Individuals and families who are on the tightest budgets must make the most difficult choices in allocating their limited resources. After paying the rent or mortgage and putting food on the table, millions of Americans simply do not have enough money to buy health insurance. The most recent Kaiser/Commonwealth Fund survey highlighted this fact; the majority of uninsured Americans polled cited cost as the primary reason they do not having health insurance.[11]

Rising Costs

Over the past decade, health insurance costs rose much faster than overall consumer prices. The U.S. General Accounting Office (GAO), the financial investigating arm of Congress, reported in 1997 that the average annual premium for employment-based family health insurance coverage increased by 111 percent from $2,530 in 1988 to $5,349 by 1996. During this same period, overall consumer prices rose by 33 percent.[12] The GAO study concludes that the continued erosion of health insurance coverage is linked explicitly to cost pressures.

A direct relationship exists between increases in health insurance costs and the number of uninsured. The CBO estimates that a 1.0 percentage point increase in the cost of health insurance forces an additional 200,000 Americans off the insurance rolls.[13] In recent testimony before Congress, economist John Sheils explained that his estimates show that 300,000 people lose health insurance for every 1.0 percentage point increase in costs.[14] The result of increases in health care costs is clear: Those who can afford premium increases least are the ones who are most likely to lose their health insurance or, in the case of smaller, more marginal businesses, to drop coverage altogether.

According to the CBO, employers respond to premium increases in a variety of ways in order to reduce the financial impact on the bottom line: They drop health insurance coverage for employees, reduce the generosity of their benefits package, increase cost-sharing for medical bills by employees, or increase each employee's share of the premium.

The Effects of Regulation

The direct link between imposing regulations and mandates on the health insurance market and the number of uninsured is well-established in the research. For example:

8. U.S. Bureau of the Census, *Current Population Survey,* March 1998.
9. Allyson G. Hall, Karen Scott Collins, and Sherry Glied, "Employer-Sponsored Health Insurance: Implications for Minority Workers," Commonwealth Fund, New York, N.Y., February 1999.
10. *Ibid.*
11. Commonwealth Fund, "Kaiser/Commonwealth 1997 National Survey of Health Insurance," New York, N.Y., December 1997.
12. U.S. General Accounting Office, "Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures," GAO/HEHS–97–122, July 1997.
13. Congressional Budget Office, "CBO's Estimate of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103."
14. Sheils, Testimony before the Subcommittee on Health, Committee on Ways and Means.

- Even before the veritable explosion in state-mandated benefits in the 1990s, a 1989 study for the Urban Institute reported that health care mandates significantly raised premium costs. The study found that health insurance was from 4 percent to 13 percent more expensive as a direct result of benefit laws.[15]
- Using data from 1989 to 1994, Duke University researchers Frank A. Sloan, Ph.D., and Christopher J. Conover, Ph.D., found that the higher the number of coverage requirements placed on plans, the higher the probability that an individual would become uninsured and the lower the probability that a person would have any private health insurance coverage, including group coverage. Their research, based on more than 100,000 observations, demonstrates that the probability an individual will become uninsured increases with each mandate imposed by government.[16]
- Professor Gail A. Jensen of Wayne State University and Professor Michael Morrisey of the University of Alabama–Birmingham reported that as many as one in four Americans lacks health insurance because of benefit mandates.[17] Each additional mandate significantly lowers the probability that a firm or an individual will have health insurance.
- Professor William S. Custer of Georgia State University found that state guaranteed issue requirements, coupled with either community rating or rate bands in the small-group insurance market, increase the probability that a person will become uninsured by nearly 29 percent.[18] These laws hit small firms and individuals purchasing insurance in the open market the hardest.

The number of state-imposed health benefit mandates has increased 25-fold over the past quarter-century, with more than 1,000 state-mandated benefit laws on the books today.[19] Most are attempts by state lawmakers to correct inefficiencies or inequitable practices in the market. Unfortunately, the mandates have the unintended effect of increasing the numbers of uninsured. Professors Jensen and Morrisey note, "Mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether."[20]

The Impact on Small Business. Small businesses and individuals attempting to purchase health insurance are hit with the full force of these mandates and insurance regulations. The small-group and individual insurance markets are more fragile and expensive as a result. Most large companies are protected under ERISA—the Employee Retirement Income Security Act of 1974, which allows companies that self-insure to escape the reach of state insurance laws and regulations and benefits mandates. Few small businesses can afford to self-insure and therefore are subject to all of the mandates and regulations imposed by the states.

Surveys conducted by the National Federation of Independent Business (NFIB) show that health insurance and health costs are the top concern of small businesses. In recent congressional testimony, the NFIB's Victoria Caldiera said that, in

15. Gregory Acs, Colin Winterbottom, and Sheila Zedlewski, "Employers' Payroll and Insurance Costs: Implications for Play or Pay Employer Mandates," *Health Benefits and the Workforce* (Washington, D.C.: U.S. Department of Labor, 1992).
16. Frank A. Sloan and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry,* Vol. 35 (1998), pp. 280–293.
17. Gail A. Jensen and Michael A. Morrisey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," Health Insurance Association of America, Washington, D.C., January 1999.
18. William S. Custer, "Health Insurance Coverage and the Uninsured," Health Insurance Association of America, Washington, D.C., December 1998.
19. Blue Cross and Blue Shield Association, *State Mandated Benefits and Providers,* December 1997.
20. Jensen and Morrisey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance."

NFIB surveys over the past 10 years, small business owners rank the cost of health insurance as their number one problem—higher even than taxes. Moreover, the NFIB's members respond in surveys that they believe providing health insurance is the right thing to do, but costs too often prohibit them from doing so.[21] Many are family-run businesses in which the employees are the spouses, sons, daughters, brothers, sisters, nieces, or nephews of the owners. Many want to offer health insurance but find its high costs prohibitive. About 40 percent of businesses with fewer than 50 workers do not offer health insurance. An employee of a company with fewer than 10 employees is three times more likely to be without health insurance than is someone working for a company with more than 1,000 employees.

Even small companies that do offer insurance often must choose between keeping the business going and offering health benefits. Many walk the line by offering insurance but requiring employees to pay a larger share of the premiums. Unfortunately, an increasing number of people decline such coverage because of rising costs.

For this and other reasons, the number of people with private health insurance has been on the decline for nearly two decades. Since 1980, the number of people with private health insurance coverage obtained either through the workplace or purchased individually declined from 79.5 percent in 1980 to 70.5 percent in 1995.[22] And it is those who have private health insurance who would be hit the hardest by the mandates of the current managed care reform legislation.

State Efforts Magnify the Problem

State efforts to regulate their health insurance markets have had a dramatic effect on the numbers of uninsured. For example, using data gathered in two GAO studies, a 1998 study conducted by the Galen Institute showed that, between 1990 and 1994, 16 states aggressively passed laws regulating their health insurance markets.[23] By 1996, the uninsured populations in these states grew an average of *eight times faster* than in the 34 states that did not pass the comprehensive regulations identified by the GAO. Before the blizzard of state health care legislation began, both groups of states showed nearly equal rates of growth in their uninsured populations.

Critics of this study claim the increase in the number of uninsured in these 16 states was caused by factors other than regulation, or that this high level of state regulation had only minimal impact. The range of employment and income characteristics of these 16 highly regulating states was similar, however, to those of the other 34 states; their distinguishing factor was their similarity in passing sweeping health insurance regulations.[24]

Kentucky was one of the most aggressive states in regulating the health care system. In 1997, Governor Paul Patton conceded in a speech to the state legislature that, "In spite of good intentions and noble purpose, it didn't work....The entire cost of the system went up."[25] In 1996, 107,500 fewer Kentucky citizens had health insurance than in 1990, and only one company still offered health insurance in the state. "In my opinion," Patton concluded, "most of the general assembly believes that we in Kentucky have experimented enough for the time being."

21. Victoria Caldiera, Testimony before the House Subcommittee on Employer-Employee Relations, 106th Cong., 1st. Sess., March 25, 1999.
22. U.S. Bureau of the Census, *Current Population Survey.*
23. Melinda Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," Heritage Foundation *Backgrounder* No. 1211, August 14, 1998. See also U.S. General Accounting Office, *Health Insurance Regulation: Variation in Recent State Employer Health Insurance Reforms,* GAO/HEHS–95–161FS, June 12, 1995, and *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,* GAO/HEHS–97–8, November 25, 1996.

In addition to Kentucky, the other states identified by the GAO as imposing sweeping insurance regulations were Idaho, Iowa, Louisiana, Maine, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Utah, Vermont, and Washington. New laws included: mandates on insurers to sell policies to anyone who applies and agrees to pay the premium—even if they wait to buy insurance until they already are sick (guaranteed issue); prohibitions on excluding coverage for some medical conditions (pre-existing condition exclusions); requirements that insurers charge the same price to everyone in a community, regardless of the differences in risks posed by the individuals (community rating), plus others.

Maryland also has a highly regulated health care system. It leads the country with nearly 50 specific state-required health benefit mandates that dictate what products or services must be covered by policies sold in the state. A 1996 report by the GAO concluded that Maryland's mandates add 22 percent to the cost of a typical health benefits package.[26]

Unfortunately, Members of Congress joined the regulatory bandwagon of the states when they enacted the Health Insurance Portability and Accountability Act of 1996, imposing at the federal level some of the same insurance rules already enacted in the states, including guaranteed renewal. As a result, it is more difficult to conduct differential comparisons of the GAO's 16 most regulating states. Nonetheless, even today, 11 of the 16 states still see the number of uninsured individuals increasing faster than the other 34 states; and in all but 2 of the remaining 5 of the 16 states, the growth in the insured population is 1.0 percent or less.[27]

WHY TAX REFORM, CHOICE, AND COMPETITION ARE NEEDED

As costs and the number of uninsured continue to rise, a different approach clearly is needed. By injecting patient choice and competition into the health care sector, many of the problems the political community is attempting to solve through legislation and regulation would be addressed by consumers in a competitive marketplace.

Consensus is growing among policy analysts across the ideological spectrum, including members of the Health Policy Consensus Group, that the key to health care reform is tax reform. The Consensus Group is a bipartisan group of health policy experts from the major market-oriented think tanks. It includes analysts from the American Enterprise Institute, the Cato Institute, The

24. The substantive findings of the Galen Institute study on insurance regulation are supported in part by other studies. Analysts at the Urban Institute, for example, attempt to quantify the impact of each state insurance reform individually. Although the Urban Institute report indicates that the provision of guaranteed issue in insurance plans by itself may decrease the number of uninsured, other policies—particularly community rating (or premium rate restrictions generally)—offset the gains from the guaranteed issue requirement. As the Urban Institute study finds, however, most states implement a "package" of reforms. At the time of the study, only five states did not include premium rate restrictions with the other small-employer insurance reforms; all the states that implemented individual insurance market reforms included some form of premium rate restrictions. Unfortunately, workers in these states could not choose the laws with which they wished to comply. Policies they purchased likely included community rating, guaranteed issue and renewal, mandates on coverage, and pre-existing condition exclusions, regardless of whether they wished to pay for them. Thus, although reforms can be evaluated individually, it is more relevant to study the overall impact of the package.

25. Governor Paul Patton, in "Health Care Special Session Remarks," a speech to the Joint Session of Kentucky's General Assembly, September 30, 1997.

26. U.S. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS–96–161, August 19, 1996. For a description of the ways in which Maryland regulates the health care system, see Dale Snyder, "Building Bureaucracy and Invading Patient Privacy: Maryland's Health Care Regulations," Heritage Foundation *Backgrounder* No. 1168, April 17, 1998.

27. U.S. Bureau of the Census, *Current Population Surveys,* March 1996, 1997, and 1998.

Heritage Foundation, the Progressive Policy Institute, the National Center for Policy Analysis, the Urban Institute, the Pacific Research Institute, the Center for Strategic and International Studies, the Institute for Research on the Economics of Taxation, the Galen Institute, the Wharton School of Business at the University of Pennsylvania, Brown University School of Medicine, and others.[28] Despite their differences, these analysts agree on one core point: The central structural defect impacting the private health insurance market is the discriminatory tax treatment of health insurance.

Inequity and Inefficiency in the Tax Code

The federal tax code heavily favors those workers fortunate enough to get health insurance through their employers. Workers do not pay taxes on the portion of their compensation package that includes health benefits so long as the employer purchases the policy for them. This generous subsidy, worth an estimated $111 billion a year,[29] is the cornerstone of the system in the United States that ties private health insurance to the workplace. But this system works against the increasing number of people in today's information-age economy who work part-time, are contract workers, or have started their own businesses. These people are disproportionately more likely to be uninsured.

Federal tax law governing employment-based health insurance distorts the efficiency of the health care market in a number of ways:

- It restricts employees' choices to the selection offered by the employer, and frustrates employees because they have little control over their policies and access to medical services;
- It undermines cost-consciousness by hiding the true cost of insurance and medical care from employees;
- Because the full cost of coverage is not known by employees, it artificially supports increased demand for medical services and more costly insurance and subsidizes inefficient health care delivery;
- It suppresses cash wages; and
- It discriminates against the self-employed, the unemployed, and those whose employers do not offer health insurance because they will receive a much less generous subsidy, if any, when they purchase health insurance on their own.

Individuals in the very lowest income categories are likely to qualify for taxpayer-supported health programs, such as Medicaid. As people move up the income scale from poverty into the lower-middle income range, the likelihood they will qualify for those public health benefit programs drops. But as people continue even further up the income scale, they are more likely to have the good jobs and higher incomes that allow them to qualify for generous, tax-subsidized, employment-based health insurance.

Working Americans with annual incomes of less than $25,000 are most likely to be caught in the trough and uninsured. They earn too much to qualify for public programs but are less likely to have jobs that provide health insurance as a tax-free benefit. In a study published in *Health Affairs,* analysts for the Lewin Group estimate that families earning less than $15,000 per year reap just $71 in tax benefits from job-based health insurance, while families making $100,000 or more get a $2,357 tax break for the purchase of health insurance.[30] This is a highly regressive subsidy, which

28. Grace-Marie Arnett, ed., *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999), forthcoming. The book includes "A Vision for Consumer-Driven Health Care Reform," the statement developed by the Consensus Group.

29. John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs,* Vol. 18, No. 2 (March/April 1999), pp. 178–181.

30. Sheils and Hogan, "Cost of Tax-Exempt Health Benefits in 1998."

drives many of the problems with cost and access that people experience in the health sector today.

What Policymakers Can Do

Some policymakers try to fill this "gap" in health coverage by creating and expanding government programs, such as the $48 billion State Children's Health Insurance Program ("S–CHIP"), and by trying to expand Medicare to middle-age Americans. But these programs send politicians and consumers deeper into the quagmire of regulation. Real solutions, however, will come from focusing on consumer choice, competition, and tax policy reforms. Many more people would gain access to the medical services and health insurance that they desire and could afford if the tax treatment of health insurance were reformed.

Specifically, Congress should consider:

1. **Targeted Tax Credits.** Federal legislators could build incentives for creating a better system and undo some of the damage done by federal and state regulation by providing targeted tax credits to the uninsured to purchase their own health insurance.

   A number of innovative tax credit bills are being introduced by legislators on both sides of the political aisle, including Representatives Richard Armey (R–TX), Pete Stark (D–CA), Jim McDermott (D–WA), Nancy Johnson (R–CT), Charles Norwood (R–GA), John Shadegg (R–AZ), and Gene Green (D–TX). In the Senate, support for equitable tax treatment of health insurance as a way to expand access has been expressed by Senators Jim Jeffords (R–VT), John Breaux (D–LA), Barbara Boxer (D–CA), Richard Durbin (D–IL), Robert Kerrey (D–NE), and Joseph Lieberman (D–CT). Many others have bills that would allow individual tax deductions for the purchase of health insurance. Tax deductions could ease the burdens of self-employed individuals, but they would not roll back the regressive nature of the current system, which provides more tax relief for those with higher incomes and a higher tax break for the purchase of more expensive health insurance policies. Tax credits would be more equitable, and they could be made refundable and targeted to those who are most likely to be uninsured. Tax credits would empower consumers to shape the health insurance market through competition rather than regulation.

   State officials could do their part by taking advantage of an immediate opportunity to provide tax credits and vouchers for uninsured children and their families through S–CHIP.[31]

2. **Alternative Purchasing Mechanisms.** There is a need to provide alternative grouping mechanisms for individuals in purchasing health insurance to receive the benefits and protections large groups enjoy. A number of mechanisms are being debated today, such as voluntary choice cooperatives, HealthMarts, and association health plans.[32]

3. **A Moratorium on Regulation and Mandates.** A moratorium on passing more insurance regulations and health benefits mandates should be imposed until their costs and impact can be examined thoroughly. Consumers are denied health coverage best-suited to their needs when government forces health plans to provide an array of benefits designed by politicians, not consumers. Such regulations and mandates drive up health care costs and make insurance more costly for individuals and families who have no choice but to purchase the policies prescribed by politicians.

31. James Frogue, "How Governors Can Help Children to Get Private Health Insurance," Heritage Foundation *Executive Memorandum* No. 591, April 23, 1999.

32. Daniel H. Johnson, Jr., M.D., "How to Expand Health Care Choice and Improve Access For Working Families," Heritage Foundation *Lecture* No. 640, July 12, 1999.

CONCLUSION

As Members of Congress once again debate health care policy, the focus is on managed care reforms that will add new levels of regulation to the health care system and provide new avenues of litigation. Clearly, Congress is responding to dissatisfaction with the current system, but it is failing to factor in the likely consequences of its actions. As the Congressional Budget Office and others warn, the major bills containing managed care regulation virtually guarantee increases in consumers' premium costs. And increased premium costs virtually guarantee that more Americans will lose health insurance coverage for themselves and their families.

Congress should try a new approach. The very best patient protection is patient choice. There is no greater restraint on the behavior of a firm than the power of consumers' dollars. Insurance companies should satisfy the wants and needs of consumers first, not those of their employers or government purchasers. Patients should be able to fire poorly performing health insurance companies, instead of being resigned to suing them in court.

Various studies illustrate that regulations at the state and federal level are counterproductive in trying to increase access to quality care in the health insurance market. The health care delivery system—at all levels—should be held directly accountable to the individuals and families being served. If increasing access and lowering costs are genuine goals of Congress, a far better approach would be to empower individuals and families to make health care choices to suit their own needs, restore the doctor–patient relationship and the independence and integrity of the medical profession, and force the health care industry and insurance companies to compete for consumers' dollars.

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