Executive Summary
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An Examination of the Bush Health Care Agenda

Robert E. Moffit, Ph.D., and Nina Owcharenko

President George W. Bush has outlined a series of health care initiatives that largely complement the proposals that he has already made—and in some cases, signed into law. The President's approach is deliberately targeted and incremental, and therefore is considerably less expansive and less expensive than Senator John Kerry's (D–MA) health plan.

A Variety of New Proposals. The President's new health care proposals are wide ranging. They include:

- The creation of refundable health care tax credits to cover millions of uninsured Americans;
- The promotion of the recently enacted Health Savings Accounts;
- An expansion of traditional public programs—the State Children's Health Insurance Program and Medicaid—to cover uninsured children;
- An expansion of federally funded community health centers and clinics;
- Major changes to the health insurance markets through the establishment of broader association health plans, state-based health insurance pools, and interstate competition among health insurance plans; and
- New tax deductions and tax exemptions to enhance long-term care coverage.

Beyond these various health insurance and tax code changes and public program expansions, the President continues to propose major changes in medical malpractice law. He also favors the promotion of information technology to streamline medical records and reduce errors, as well as new initiatives to combat the unresolved problems of waste, fraud, and abuse that continue to plague the giant Medicare and Medicaid programs.

Building on a Mixed Record. The President supported and signed into law the Medicare Modernization Act of 2003, creating a universal entitlement of unknown cost for prescription drug coverage within Medicare. It is the largest entitlement expansion since the Great Society. It will add significantly to the unfunded liabilities of the Medicare program and impose higher taxes on individuals and families.

By signing the Medicare Modernization Act of 2003, President Bush also secured the enactment of Health Savings Accounts, a new health care savings option. This one change in the law holds the potential of broadening direct personal control over health care decisions, while substantially improving and transforming America's health insurance markets.

This paper, in its entirety, can be found at:
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The President signed into law a limited health care tax credit for certain displaced workers under the Trade Adjustment Act of 2002. The Bush Administration has also promoted greater flexibility for states to expand coverage in innovative ways under Medicaid and the State Children's Health Insurance Program and bolstered community health centers to provide care for low-income persons.

Costs and Consequences. There are a variety of recent estimates of the costs and the consequences of expanded coverage under both the Bush and the Kerry health plans. The true cost of the new Medicare law is unknown.

Beyond the Medicare legislation, the Lewin Group, a prominent econometrics firm modeling health care proposals, estimates that President Bush's health care proposals would increase total federal expenditures by an additional $227.5 billion over 10 years, while reducing the number of the uninsured by 17 percent, or 8.2 million. White House officials anticipate that the President's policy initiatives would produce a more robust expansion of health care coverage, reducing the number of uninsured by 11 million to 17.5 million Americans. Other analysts have different estimates based on different assumptions.

Conclusion. The Bush health care policy proposals are generally designed to reinforce the private sector's capacity to expand health coverage and improve the delivery of medical services to Americans. A key achievement of the Bush proposals, if properly implemented, would be to increase personal control and private ownership of health insurance policies.

—Robert E. Moffit, Ph.D., is Director of and Nina Owcharenko is Senior Policy Analyst for Health Care in the Center for Health Policy Studies at The Heritage Foundation.

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President George W. Bush has outlined a series of health care initiatives that largely complement the proposals that he has already made—and in some cases, signed into law.[1]

In signing the new Medicare prescription drug bill into law, the President presided over the largest entitlement expansion since the Great Society. Beyond the new Medicare law, the President has proposed a variety of solutions to different problems within the health care system. Like Senator John Kerry (D–MA), President Bush has not proposed a single comprehensive health care plan, but rather an array of specific health policy initiatives. The President's approach is deliberately targeted and incremental, and therefore is considerably less expansive and less expensive than the Kerry health plan.

The Bush proposals for making coverage more affordable entail a limited expansion of government health programs. In general, however, the new Bush health care policy proposals are designed to reinforce the private sector's capacity to expand health coverage and improve the delivery of medical services to Americans. If they take root, these proposals could very well be transformative, improving the financing and delivery of medical services as well as the quality of health care available to the American people. A key achievement of the Bush proposals, if properly implemented, would be to increase personal control and private ownership of health insurance policies.

Talking Points

- According to the Lewin Group, the President's proposed health care agenda would reduce the number of uninsured by 8.2 million persons (17 percent) at an estimated federal cost of $227.5 billion over a 10-year period.
- The President's proposals for expanding access to health insurance would also increase Americans' personal ownership and control over health insurance and could transform the health insurance markets and restore the traditional doctor-patient relationship.
- The President's health insurance market reform proposals would dramatically expand the geographic competition among health plans.
- The President's universal Medicare drug benefit is the largest entitlement expansion since the Great Society. It will add to the unfunded liabilities of the Medicare program and impose increasingly higher taxes on individuals and families.

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Entitlement Expansion and Incremental Change

The President supported and signed into law the Medicare Modernization Act of 2003, creating a universal entitlement of unknown cost for prescription drug coverage within Medicare. While the Medicare law is scheduled to go into full effect in 2006, the Administration has taken upon itself the monumental task of administering the complex new drug benefit, trying to balance competing interests in the formulation of complex rules and regulations, setting up a new Medicare Advantage system of competing private plans, and preparing seniors for enrollment in a complex new drug program.

By signing the Medicare Modernization Act of 2003, President Bush also secured the enactment of Health Savings Accounts (HSAs), a new health care savings option available to Americans. This one change in the law holds the potential of improving and transforming America's health insurance markets.

The President signed into law a limited health care tax credit for certain displaced workers under the Trade Adjustment Act of 2002. The Administration also promoted greater flexibility for states to expand coverage in innovative ways under Medicaid and the State Children's Health Insurance Program (S-CHIP) and bolstered community health centers to provide for low-income persons.

A Variety of New Proposals. The President's new health care proposals are wide ranging. They include:

- Refundable health care tax credits to cover millions of uninsured Americans;
- The promotion of the recently enacted Health Savings Accounts;
- An expansion of traditional public programs—S-CHIP and Medicaid—to cover uninsured children;
- An expansion of federally funded community health centers and clinics;
- Major changes to the health insurance markets through the establishment of broader association health plans, state-based health insurance pools, and interstate competition among health insurance plans; and
- Tax deductions and tax exemptions to enhance long-term care and to cope with a rapidly aging population.

Beyond these various health insurance and tax code changes, the President continues to propose major changes in medical malpractice law. He also favors the enactment of patients' rights legislation that would facilitate access to specialists and promote information technology to streamline medical records and reduce errors, as well as new initiatives to combat the unresolved problems of waste, fraud, and abuse that continue to plague the giant Medicare and Medicaid programs.

Costs and Consequences. There are a variety of recent estimates of the costs and consequences of expanded coverage under both the Bush and the Kerry health plans. Earlier this year, the Bush Administration estimated that the new Medicare law would cost $534 billion over its first 10 years.[2]

Beyond the Medicare legislation, the Lewin Group, a prominent econometrics firm modeling health care proposals, estimates that President Bush's health care proposals would increase total federal expenditures by an additional $227.5 billion over 10 years.[3] The Lewin Group projects that this level of federal expenditure will reduce the number of uninsured by 17 percent or 8.2 million.[4] White House officials anticipate that the

1. The new Bush health care proposals are outlined in The White House, "President Bush's Plan to Make Health Care More Affordable," September 2004, at *www.whitehouse.gov/news/releases/2004/09/20040902.html* (October 6, 2004).
2. See Robert E. Moffit and Brian M. Riedl, "Medicare's Deepening Financial Crisis: The High Price of Fiscal Irresponsibility," Heritage Foundation *Backgrounder* No. 1740, March 25, 2004, at *www.heritage.org/research/healthcare/bg1740.cfm*.
3. Lewin Group, "Bush and Kerry Health Care Proposals: Cost and Coverage Compared," September 21, 2004, p. vi, at *www.lewin.com/NR/rdonlyres/e3atrfxcgu4ge5exrxwbqcespnrtjpckiofchqjmc47ucccnysofc25cdom67s42ng2b446i7dnfyj/LewinAnalysisCandidatesProposals.pdf* (October 6, 2004).

President's policy initiatives would produce a more robust expansion of health care coverage, reducing the number of uninsured by 11 million to 17.5 million Americans.[5] Other analysts have different estimates based on different assumptions.[6]

The Bush Health Care Record

With the enactment of the Medicare Modernization Act of 2003, President Bush has presided over the largest entitlement expansion since the Great Society. While the massive law (to be fully implemented in 2006) adds a complex drug benefit to the Medicare program, it does help low-income seniors to secure access to coverage. However, because the drug benefit is an open-ended entitlement, not simply targeted to poor seniors without coverage, the new law will worsen Medicare's already deepening financial problems.[7] Although prominent House and Senate Democratic leaders have belatedly complained about the higher-than-estimated cost of the Medicare law, many of these same leaders are on record for supporting an initial Medicare drug benefit that was at least twice as expensive as the version enacted into law. [8]

Medicare's Exploding Costs. Regardless of the validity of the initial 10-year cost estimates of the drug provisions—a source of bitter controversy—there is little doubt that these costs will soar dramatically (perhaps by as much as $2 trillion) in the second decade,[9] when the baby boom retirement starts to accelerate. Meanwhile, the Medicare Trustees have indicated that the new drug benefit alone will add a stunning $8.1 trillion to the unfunded Medicare liability, which now totals $28 trillion.[10] Curiously, while the President and Congress are both clearly committed to this massive entitlement expansion, neither Congress nor the President have indicated precisely how they will pay for these promised Medicare benefits.

Beyond the shocking price tag of the Medicare drug entitlement, its 2006 implementation promises to be difficult and disruptive for millions of senior citizens, because most senior citizens (roughly three out of four) already have some form of prescription drug coverage.[11] Instead of targeting taxpayer dollars to the minority of seniors without drug coverage, the President and Congress created a universal entitlement to a complex and confusing drug benefit, including big gaps in coverage. The design has no parallel in private sector experience. Nonetheless, its universality will "crowd out" existing drug coverage, including the

4. *Ibid.*
5. The White House, "President Bush's Plan to Make Health Care More Affordable," p. 1.
6. Joseph Antos, Roland (Guy) King, Donald Muse, Tom Wildsmith, and Judy Xathopoulos, "Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact," American Enterprise Institute, September 13, 2004, at *www.aei.org/docLib/20040913_KerryBushHealthPlans.pdf* (September 30, 2004). See also John C. Goodman, "Bush Health Plan: Consumer-Driven Health Care," National Center for Policy Analysis *Brief Analysis* No. 486, September 20, 2004, at *www.ncpa.org/pub/ba/ba486/* (October 6, 2004).
7. For a discussion of the future financial pressures created by the Medicare Modernization Act of 2003, see Moffit and Riedl, "Medicare's Deepening Financial Crisis." See also Robert E. Moffit, Ph.D., Thomas R. Saving, Ph.D., and Jeff Lemieux, "What Will Medicare's Future Hold for Seniors and Taxpayers?" Heritage Foundation *Lecture* No. 797, September 23, 2003, at *www.heritage.org/research/healthcare/hl797.cfm*.
8. Robert Pear, "Democrats Demand Inquiry Into Charge by Medicare Officer," *The New York Times*, March 14, 2004, p. 1.
9. See Douglas Holtz Eakin, "The Cost of Medicare: What the Future Holds," Heritage Foundation *Lecture* No. 815, December 15, 2003, at *www.heritage.org/research/healthcare/hl815.cfm*.
10. Thomas R. Saving, "How Are We to Pay for All This?" *The Wall Street Journal*, September 22, 2004, p. A28.
11. See Robin Toner and Robert Pear, "House Committee Approves Drug Benefits for Medicare," *The New York Times,* June 18, 2003, p. A19; Edmund F. Haislmaier, "How Congress Would Reduce Seniors' Existing Private Coverage," Heritage Foundation *Backgrounder* No. 1668, July 17, 2003, at *www.heritage.org/research/healthcare/bg1668.cfm*; and Derek Hunter, "Recent Research Confirms That Seniors Will Lose Coverage Under New Medicare Legislation," Heritage Foundation *WebMemo* No. 345, October 7, 2003, at *www.heritage.org/Research/HealthCare/wm345.cfm*.

drug coverage provided in employment-based retiree coverage. The Congressional Budget Office and independent analysts have indicated that roughly one-third of seniors with employer-based drug coverage would lose their coverage or find their coverage significantly scaled back due to the new law.[12] This large class of retirees would generally end up paying more out of pocket for an inferior government drug benefit.

The new Medicare law also falls far short of serious reform, the point of the national Medicare debate in the first place. In 1999, a majority of members of the National Bipartisan Commission on the Future of Medicare unveiled a comprehensive "premium support" system, which would have transformed Medicare into a program similar to the Federal Employees Health Benefits Program (FEHBP), which covers federal workers and retirees and is a successful model of consumer choice and competition.[13] Although the House version of the Medicare Modernization Act of 2003 contained such a proposal, to become effective in 2010, the Senate version did not. The crucial Medicare reform provision was dropped in the House and Senate conference committee in favor of a weak and limited "premium support" demonstration project.[14] Thus, the President and Congress squandered a historic opportunity to reform the program and cope with the impending massive retirement of the baby boom generation.

One particularly promising feature of the new Medicare law is the Medicare Drug Discount Card program. The program enables seniors to choose among competing drug discount cards and secure savings from the retail price of drugs. Poor seniors would also be eligible for an annual $600 subsidy. Effective on June 1, 2004, the program has already enrolled over 4 million out of a targeted pool of 7.2 million seniors without drug coverage. Based on the evidence thus far, low-income seniors have been able to secure significant savings from the program, ranging from 32 percent to 85 percent.[15] Unless Congress changes current law, this promising program will end in January 2006.

Health Savings Accounts. With the Medicare Modernization Act of 2003, the President also secured the enactment of Health Savings Accounts as another health care option for the non-Medicare population. Combined with a high-deductible health plan, HSAs enable employers and employees to deposit funds tax-free (up to a maximum of $2,600 for an individual and a maximum of $5,150 for a family) into an account to pay for their medical expenses.[16] Persons over age 55 would be able to make an additional tax-free contribution of $500 in 2004 and up to an additional $1,000 contribution in 2009. Even Medicare enrollees, while no longer legally able to make tax-free contributions to such accounts, could draw down on these accounts to pay for various health-related expenses.

HSAs are portable, meaning individuals can take the accounts with them from job to job. The funds in these accounts and any interest earned on these accounts can be carried over from year to

12. Haislmaier, "How Congress Would Reduce Seniors' Existing Private Coverage."
13. For more information about this historic bipartisan effort, see Stuart M. Butler, "Principles for a Bipartisan Reform of Medicare," Heritage Foundation *Backgrounder* No. 1247, January 29, 1999, at *www.heritage.org/Research/HealthCare/BG1247.cfm*.
14. For more information about this congressional retreat from Medicare reform, see Robert E. Moffit, "A 'Demonstration Project' Equals No Medicare Reform," Heritage Foundation *Backgrounder* No. 1708, November 19, 2003, at *www.heritage.org/Research/HealthCare/BG1708.cfm*.
15. Derek Hunter, "The Medicare Drug Discount Cards: One Month In," Heritage Foundation *WebMemo* No. 538, July 15, 2004, at *www.heritage.org/Research/HealthCare/wm538.cfm*. See also Grace-Marie Turner and Joseph R. Antos, Ph.D., "The Medicare Drug Discount Card: First Phase of a Market Revolution?" Heritage Foundation *Lecture* No. 846, July 30, 2004, at *www.heritage.org/Research/HealthCare/hl846.cfm*.
16. The new Health Savings Accounts are an improved version of the Archer medical savings accounts, which were enacted in the Health Insurance Portability and Accountability Act of 1996. They are not burdened, however, with the same artificial legislative and regulatory restrictions that hobbled medical savings accounts. For more information about HSAs, see U.S. Department of the Treasury, "Health Savings Accounts," at *www.ustreas.gov/offices/public-affairs/hsa/* (October 7, 2004).

year tax-free and used without tax penalty to pay for a variety of qualified medical expenses.

Based on preliminary evidence, the Health Savings Accounts appeal to diverse age and income groups. They have a strong appeal to both large and small businesses, and they are broadly affordable for individuals and families.[17] In 2005, 18 high-deductible health plans, including Health Savings Accounts and health reimbursement account plans, will also be among the 249 health plans available to federal workers and retirees in the Federal Employees Health Benefits Program.[18]

By introducing a high degree of personal control over health care spending and sharply reducing administrative costs at the point of delivery, HSAs could dramatically transform the health insurance markets. They could also reduce paperwork and unwanted third-party payment interventions in the financing and delivery of medical services, and restore the traditional doctor-patient relationship.

Trade Bill Tax Credits. The President also signed into law a health care tax credit under the Trade Adjustment Act of 2002 (TAA).[19] The special tax credit would cover 65 percent of the cost of coverage for workers displaced by international trade and persons eligible for coverage under the Pension Benefit Guaranty Corporation. Under this law, Congress established federal rules for eligibility and the kinds of coverage that would be acceptable, giving states the ability to design coverage arrangements within specified statutory parameters. The population eligible for coverage is very small—between 200,000 and 300,000 persons nationwide.[20] Tax credit payments to health insurers started in August 2003, and by February 2004 approximately 4 percent of the eligible population had taken advantage of the advanced payment program.[21]

While the administration of the TAA tax credit is little more than one year old, its implementation has been troubled. Many of its difficulties are administrative and traceable to statutory design problems. The complexity of the enrollment process and other issues are highlighted in a recent Government Accountability Office report.[22] Nonetheless, the TAA tax credit experience can provide guidance for further expanding coverage through health care tax credits. Although limited in scope, the administrative infrastructure, with some helpful legislative adjustments to reduce the complexity of administration, could facilitate rapid expansion of health care coverage under the President's proposed refundable tax credit program.[23]

Congressional Obstruction. Before the enactment of the TAA tax credit, the President in 2001 and 2002 supported two major health care tax credit proposals, worth $13 billion and $15 billion, respectively, to provide health care coverage for displaced workers as part of a multi-billion dollar economic stimulus package. While the House passed these generous health care tax credit proposals twice—in December 2001, and again in February 2002—the

17. For an excellent account of the progress and promise of HSAs, see Bill McInturff, John Goodman, Robert Hurley, and Stuart Slutzky, "Is Consumer-Directed Health Care Reshaping the Health Care System," National Center for Policy Analysis *Congressional Briefing*, April 21, 2004, at *www.ncpa.org/evn/washington/20040421wash.htm* (October 6, 2004).

18. U.S. Office of Personnel Management, "The Federal Employees Health Benefits Program Fact Sheet," September 14, 2004.

19. See Internal Revenue Service, "Health Coverage Tax Credit (HCTC) Overview," at *www.irs.gov/individuals/article/0,,id=109960,00.html* (October 1, 2004).

20. Stan Dorn, "How Can National Policymakers Improve Health Coverage Tax Credits Provided Under the Trade Act of 2002," Economic and Social Research Institute, May 2004, p. iii, at *www.pnhp.org/news/2004/may/how_can_national_pol.php* (October 6, 2004).

21. *Ibid.*

22. U.S. Government Accountability Office, "Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation," September 2004, at *www.gao.gov/new.items/d041029.pdf* (October 6, 2004).

23. For discussion of the TAA tax credit, see Nina Owcharenko and Edmund F. Haislmaier, "State Opportunities to Provide Affordable Health Coverage Under the Trade Law," Heritage Foundation *Backgrounder* No. 1626, February 25, 2003, at *www.heritage.org/Research/HealthCare/bg1626.cfm*.

Senate blocked them on both occasions.[24] The proposals would have provided a 60 percent refundable tax credit for health insurance for displaced workers who had lost their insurance coverage.

Neither the House nor the Senate acted upon the President's central proposal to enact a more comprehensive program to cover the uninsured, which would have provided income-based tax credits of $1,000 per individual and $3,000 per family. Congress failed to enact the President's proposal to establish association health plans, which would enable small businesses to pool together to provide affordable coverage for their workers. Congress also failed to enact the President's proposal to allow a tax-free rollover of funds in flexible spending accounts to be used for the payment of routine medical services.

Medicaid Waivers. The President has also undertaken several administrative steps to expand access to health care coverage. Through various waivers, including the Health Insurance Flexibility and Accountability (HIFA) waiver, administered by the Department of Health and Human Services (HHS), the Bush Administration has given states greater flexibility to expand coverage options, including private and employer-based coverage, for an estimated 2.6 million low-income workers and their families using the Medicaid and S-CHIP programs. Thus far, HHS has approved a small number of HIFA demonstrations. Unfortunately, states officials' applications for the special waivers have generally not been an innovative exercise in robust change. Another key problem is that many states are struggling with Medicaid-related budget constraints.[25]

The Bush Administration has also opened or expanded 600 community health centers, which deliver care to an additional 3 million persons. Under the continuation of this community health center expansion, the White House projects an additional 6.1 million persons will be served through these centers by 2006.[26]

Tort Reform. During his first term, the President aggressively supported enactment of medical malpractice reform laws. The President's tort reform package includes the capping of non-economic damages at $250,000, limitations on punitive damages, restrictions on lump sum payments in favor of payments over time, and the provision for unlimited compensation for economic damages (such as loss of income). While the House of Representatives passed the President's tort reform proposals, the Senate repeatedly blocked them.

How the Bush Plan Would Expand Insurance Coverage

The President has outlined several changes in the tax laws to encourage and expand private sector coverage. The plan targets both low-income individuals and families and also encourages individuals, families, and small businesses to take advantage of the benefits of the new Health Savings Accounts.

Individual and Family Tax Credits and Deductions. Specifically, the President proposes to promote Health Savings Accounts for low-income workers and their families. His proposal would provide low-income families with $1,000 deposited directly into their HSAs and a $2,000 refundable, advanceable health care tax credit for purchasing a high-deductible health plan. Individuals would receive a $300 HSA federal contribution and a $700 refundable, advanceable tax credit for purchasing a high-deductible health plan.

Alternatively, the President would provide a $3,000 refundable, advanceable health care tax credit for those families that choose not to establish a HSA.[27] Under the Bush health care tax credit proposal, individuals would be eligible for a tax credit worth up to $1,000 for the purchase of health insurance policies of their choice.

24. Senate Democrats, like their House counterparts, mostly favored Medicaid expansion and tax credits restricted to COBRA coverage only. The Bush proposal would have allowed the credit to be used for COBRA and other health insurance coverage.

25. See Theresa Sachs, "HIFA at Age Two: Opportunities and Limitations for States," Academy Health *Issue Brief*, Vol. 4, No. 6 (November 2003), at *www.statecoverage.net/pdf/issuebrief1103hifa.pdf* (October 1, 2004).

26. The White House, "President Bush's Plan to Make Health Care More Affordable," p. 2.

The parameters and execution of the latest version of the Administration's health care tax credits are unclear. If these credits are designed similarly to those put forth by the President in past years, individuals with an annual adjusted gross income of $15,000 or less would receive the full $1,000 and families with an income of $25,000 or less would receive the full $3,000 family credit. From there, the credit would decrease on a sliding scale for individuals up to an income of $30,000 and for families up to an income of $60,000.[28]

The President would provide an above-the-line deduction[29] for health insurance premiums connected with high-deductible health plans. Individuals who purchase a high-deductible health insurance policy would be able to deduct the premium from their taxes. This would encourage families and individuals to open Health Savings Accounts.

The President also proposes a special HSA tax credit to help promote Health Savings Accounts among small businesses. The proposal would provide small-business owners with a special tax credit on HSA contributions for the first $500 contribution to an employee's family policy and for the first $200 contribution to an employee's individual policy.

According to the Lewin Group, over the first 10 years of their implementation, the President's tax credit proposals would amount to a $128.8 billion expenditure, and the Health Savings Account tax breaks would amount to $48 billion expenditure.[30]

Analysis. There is a powerful consensus among health policy analysts that the existing tax treatment of health insurance is a major flaw in America's health care system.[31] Under current law, Americans with employer-based health insurance get unlimited tax breaks for the purchase of their coverage. This tax policy, a remnant of the 1940s and 1950s, has worked very well in expanding coverage through group insurance ever since World War II.

In recent years, however, the drawbacks of current policy have become increasingly apparent. By tying insurance to the workplace, the current policy has undermined both access to and portability of health insurance, and it has created gaps in coverage and fueled health care inflation. Moreover, the current policy is inequitable and disproportionately favors upper-income workers with generous corporate health benefits packages.

The President is proposing a set of limited health care tax credits and deductions to address existing coverage problems. Multiplying tax credits is not the best tax policy, and multiplying special tax breaks runs counter to comprehensive tax reform and simplifying the federal tax code. However, if the nation is going to promote broadly expanded health care coverage through private sector insurance, expand personal freedom of choice, and enhance competition among health plans and medical professionals, then health care tax credits, that benefit low-income individuals and families and enable them to choose the best arrangement for their health care, including Health Savings Accounts, are the best means to accomplish that end.

Ideally, all existing tax breaks for employer-based health insurance would be replaced with a national system of refundable health care tax cred-

27. This is a variation on the President's original health care tax credit proposal. See Nina Owcharenko and Robert E. Moffit, Ph.D., "How the President's Health Care Plan Would Expand Insurance Coverage to the Uninsured," Heritage Foundation *Backgrounder* No. 1636, March 11, 2003, at *www.heritage.org/research/healthcare/bg1636.cfm*.

28. U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2004 Revenue Proposals*, February 2003, pp. 45–47, at *www.treas.gov/offices/tax-policy/library/bluebk03.pdf* (October 6, 2004).

29. An "above-the-line deduction" is a tax deduction that adjusts the amount of income one pays in taxes.

30. John Shiels and Randall Haught, "Bush and Kerry Health Care Proposals: Cost and Coverage Compared," Lewin Group, September 21, 2004, p. 5, at *www.lewin.com/NR/rdonlyres/e3atrfxcgu4ge5exrxwbqcespnrtjpckiofchqjmc47ucccnysofc25cdom67s42ng2b446i7dnfyj/LewinAnalysisCandidatesProposals.pdf* (September 30, 2004).

31. The policy consensus is broad and bipartisan, including analysts ranging from the American Enterprise Institute to the Progressive Policy Institute. For an in-depth discussion of this issue, see Grace Marie Arnett, ed., *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor, Mich.: University of Michigan Press, 1999).

its.[32] This would provide direct and immediate assistance to American families, enabling them to pick the plan or option of their choice. Strict neutrality in the tax code would foster a level playing field for intense competition among different health plans and enhance personal control over key health care decisions.

The President's proposal, although short of a universal solution, would create new alternatives for the uninsured population, particularly those who do not receive health insurance through the workplace. His is a limited, but targeted tax credit to those in need, and would create a consumer-driven system parallel to the conventional system of employer-based health insurance. His proposals would also expand personal control and ownership of health insurance policies.

The President's latest proposals to alter the tax treatment of health insurance are largely a continuation of his earlier health care tax credit proposals, but with special—and favorable—treatment targeted to high-deductible health plans and HSA options. The Bush proposal:

- **Targets federal assistance to low-income families and individuals purchasing health care coverage.** The Bush plan would provide low-income families and individuals with federal assistance to purchase their own health care policies. Families and individuals would be able to select the plan that best suits their needs, whether a traditional health insurance plan or a new Health Savings Account.

  The tax credit would be refundable so that even if families owe little or no taxes, they would still qualify for the credit. It would also be advanceable so that they would receive the credit when premiums are due instead of waiting for the end of the year.

- **Adds to the favorable tax treatment of employment-based health insurance with a special business tax credit.** This is a problem. Today, both large and small businesses that provide health care coverage can already deduct 100 percent of the costs, and employer contributions to an employee's Health Savings Account is treated as employer provided coverage. The President is correct in recognizing that the problem of the uninsured is largely inseparable from small-business employment, where a disproportionate share of the working uninsured are located. However, given the growing demands on the federal budget, increasingly scarce federal resources should not be used to reinforce the generous tax benefits already available to businesses offering health care coverage, even small businesses.

- **Offers a special deduction for a High Deductible Health Plan, which would distort the health market and the tax code by favoring one type of coverage arrangement over another.** The Bush plan would enable individuals purchasing a high deductible health plan to take an above-the-line deduction on the premium. This simply creates another layer of complexity in how the tax code treats the way health care is obtained, by favoring one health plan design over another. Good public policy is not advanced by preserving the inequity of the current tax code and compounding it with special favorable treatment for high deductible health plans, however desirable they may be.

A Better Approach. Understanding that the overwhelming majority of uninsured Americans are low-income, working uninsured, policymakers should build on the strengths of the individual tax credit approach originally put forth by the President and focus those efforts on workers in small businesses.[33]

Furthermore, instead of creating a new set of additional financial incentives for small businesses, policymakers should relieve the pressure on small businesses and allow them to make defined contri-

32. This was The Heritage Foundation's comprehensive proposal for universal coverage, first unveiled in 1989. For an updated analysis of the Heritage proposal, see John Sheils and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," prepared for the National Coalition on Health Care by the Lewin Group, October 18, 1999, pp. 41–52, at *www.nchc.org/releases/healthinstaxes_10_18_99.html* (October 6, 2004).

butions of whatever amount they feel that they can afford to their employee's chosen plan, with the employer contribution remaining tax-free to both the worker and the employer. This would enable businesses that find it difficult to offer employer group coverage to at least offer their employees some assistance in purchasing health insurance. For low-income workers who qualify for a federal tax credit, the employer's tax-free contribution would help supplement the tax credit.

How the Bush Plan Would Improve Health Insurance Markets

The existing health insurance markets are distorted by outdated federal and state tax codes and are burdened by an increasingly complex set of federal and state regulatory barriers. They are also plagued by artificial geographical and group restrictions. Together, these factors are an impediment to a full and robust system of consumer choice and competition in the health care sector. The President is offering a number of innovative proposals that would change the existing health insurance markets.

Specifically, the President would allow small businesses to establish Association Health Plans (AHPs). This change would enable small businesses to band together through trade associations to purchase coverage for their employees. Moreover, the President would expand AHPs beyond conventional business arrangements, in which businesses compose the associations. Under this proposal, association health plans could be sponsored by a variety of organizations, including civic and charitable groups, unions, trade associations, fraternal and ethnic organizations, churches, and religious and faith-based organizations. All of these kinds of associations could offer coverage to their members, providing robust alternatives to the constrained and constricted health insurance options available to individuals in so many state insurance markets today.

The President's proposal would also permit individuals to purchase health care coverage from insurance companies in other states. This would allow a genuinely national health insurance market to develop. With a national market—combined with tax credits, new individual Association Health Plans, and Health Savings Accounts—insurers would be able to establish national pools, enrolling potentially millions of people. Information on the benefits and services of health plans, as well as the performance of providers, could intensify competition. As Michael Porter and Elizabeth Olmstead Teisberg observe, consumers would benefit enormously from a geographic expansion of competition in the health care sector of the economy, moving from artificial local markets to regional and national markets.[34]

Finally, the President would provide grant funding for states to establish state-run health insurance purchasing pools ("health pools") to make purchasing health care coverage easier and less costly for state residents.

Analysis. The President has introduced several innovative changes to the health insurance markets. If these changes are enacted, they would improve both access and efficiency of coverage for millions of Americans. Specifically, the Bush proposal:

- **Expands coverage options for small businesses through associations.** AHPs would offer small businesses an alternative way to provide health care coverage to their employees. While pooling together would provide small business with some relief, there are a variety of reasons why small businesses may not be the best or most efficient vehicle for providing coverage for workers, including higher worker turnover rates and greater share of part-time and seasonal workers. Furthermore, employees would still be at the mercy of employers' benefit and coverage decisions. Policymakers should

33. For a discussion about how this could be done, see Stuart Butler, Ph.D., "Reducing Uninsurance by Reforming Health Insurance in the Small Business Sector," Heritage Foundation *Backgrounder* No. 1769, June 17, 2004, at *www.heritage.org/Research/HealthCare/bg1769.cfm*.

34. Michael E. Porter and Elizabeth Olmstead Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004, pp. 70–71.

realize that traditional employer-sponsored coverage is outdated and may no longer be an ideal arrangement for small businesses or today's workers and their families. Today's workers need health insurance portability. Individuals should have the freedom to choose the style and type of coverage arrangement that best suits their needs and their families and to own and keep their preferred coverage when they change employers.

- **Promotes long-term coverage arrangements through individual membership associations.** Pooling people together is an important tool to enhance purchasing power and ensure more equitable risk-spreading, which is a key function of insurance. However, unlike pooling people together simply through the workplace, individual membership groups provide a longer lasting and far more stable arrangement. Individuals would also be able to associate themselves with a large group that best represents them and their ethical and moral values, including faith-based and religious sponsors of health insurance.[35] This is particularly important for many conscientious individuals who understand and appreciate the broader ethical challenges, as well as the tremendous opportunities, presented by the biomedical revolution. What happens in the laboratory eventually finds its way into new medical treatments and procedures, and these developments are inseparable from grave moral and ethical considerations. This applies with a special urgency to advances in genetic research.
- **Creates competition among states to develop affordable coverage options.** Each state regulates individually purchased and commercial group health insurance plans. In a number of states, costly regulations—such as benefit mandates or the imposition of rigid insurance rules—raise health care costs and discourage health plan participation. These public policies can also price individuals and employers out of the insurance market, particularly individuals and families working in small businesses or marginally profitable enterprises.

  Some states have begun to remove such costly regulations, and more and more state officials are working to make coverage more affordable by changing insurance rules or allowing insurers to offer less comprehensive health benefit packages. Under the Bush proposal, with basic consumer protections in place, individuals and small businesses would be allowed to shop in other state insurance markets. This would not only reward reform-minded states that are working to reduce unnecessary health care costs, but also encourage other states to adopt reforms to keep their own health insurance plans competitive.

  On a cautionary note, one inevitable by-product of increasing interstate commerce in health insurance would be increasing federal regulation of health insurance on a much greater scale than exists today. A trend toward the federalization of health insurance regulation is already well underway. For example, the federal government is exercising limited regulatory authority over health insurance plans through the Health Insurance Portability and Accountability Act of 1996. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, employers are required to maintain group coverage for separated workers and their families on a self-paying basis for 18, 24, or 36 months. Federal rules also govern private self-insured health plans under the Employee Retirement Income Security Act of 1974, which, among other things, enables these employer-based health plans to avoid state mandates and state premium taxes.

  While federal regulation of health insurance would be inevitable, the creation of a robust national health insurance market could improve access to coverage. The growth of interstate commerce in health plans would also intensify competition and improve a range of choices for millions of Americans.

35. For a discussion of the role that faith-based and religious organizations can play in the sponsorship of health insurance, see Phyllis Berry Myers, Richard Swenson, M.D., Michael O'Dea, and Robert E. Moffit, Ph.D., "Why It's Time for Faith Based Health Insurance," Heritage Foundation *Lecture* No. 1850, August 24, 2004, at *www.heritage.org/Research/HealthCare/hl850.cfm*.

- **Encourages states to design more consumer-friendly marketplaces.** For Americans who are dissatisfied with the insurance offered by their employers or fear leaving a job because they would lose their existing job-based coverage, getting good and affordable coverage outside the workplace is often complicated and frustrating.

  States need to create a new market environment in which individuals can compare and select from an assortment of coverage options. Currently, states have jurisdiction over health insurance and often govern these health insurance markets with a formidable regulatory regime, including state-mandated benefits, treatments, and procedures. Under the Bush proposal, with assistance from the federal government, states could consider restructuring their insurance markets. For example, they could replace mandated benefits with basic coverage requirements, as is the practice in the Federal Employees Health Benefits Program. Moreover, in the spirit of the FEHBP, they could fashion a new and more robust small group or individual insurance market, attracting an increasing number of carriers. State insurance market reforms could be governed by the FEHBP's best features: broad consumer choice, real insurance competition, and minimal regulation.[36] Such an approach would allow individuals and families to choose from a menu of competing health coverage options without unnecessary interference or outdated market restrictions by state officials.

How the Bush Plan Would Expand Government Health Programs

While the bulk of President Bush's effort is dedicated to expanding health coverage through private sector institutions, the President's proposal also includes an expansion of public program coverage, particularly for children and low-income individuals and families. According to the White House, the number of low-income children enrolled in S-CHIP jumped from 3.3 million in 2000 to 5.8 million in 2003, a 75 percent increase in enrollment. [37] Meanwhile, the Bush Administration has presided over an increase of 6.8 million low-income adults and children in Medicaid, the joint federal–state program that covers the poor and the indigent, and opened or expanded community health centers, which served an additional 3 million people.[38]

The President has outlined a $1 billion outreach effort: the Cover the Kids Campaign. This campaign would enroll eligible children in the Medicaid and S-CHIP programs by having the federal government team up with states and community organizations. According to the Lewin Group, the Bush Medicaid proposal would amount to an additional $9.4 billion in spending over 10 years.[39]

The President also proposes expanding the number of health centers in rural and poor counties to ensure that the poorest Americans have access to vital health care services, and maintaining his commitment to reaching an additional 6.1 million people by 2006.[40]

Analysis. Medicaid is a welfare program. It is also a substandard program plagued by low reimbursement levels for doctors, hospitals, and other medical professionals. Members of Congress know that few Americans would voluntarily give up their private health insurance to enroll in Medicaid. Moreover, surveys of the uninsured show that, given the opportunity, they would prefer to enroll in private sector health plans rather than Medicaid.[41] In point of fact, neither Medicaid nor S-CHIP have been efficient in securing coverage for uninsured children. Indeed, 56 percent of all uninsured

36. For a discussion of this approach at the state level, see Robert E. Moffit, Ph.D., and Nina Owcharenko, "Covering the Uninsured: How States Can Expand and Improve Health Care Coverage," Heritage Foundation *Backgrounder* No. 1637, March 14, 2003, at *www.heritage.org/Research/HealthCare/bg1637.cfm*.

37. The White House, "President Bush's Plan to Make Health Care More Affordable," p. 5.

38. *Ibid,* pp. 5, 2.

39. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 7.

40. The White House, "President Bush's Plan to Make Health Care More Affordable," p. 2.

children are eligible for enrollment in Medicaid or S-CHIP, but are not enrolled in either program.[42]

The expansion of community health centers may be necessary to deal directly with critical physician shortages in certain areas of the nation, particularly in rural counties or medically underserved areas. However, it is a short-term solution. It is no substitute for a broader system-wide change, fueled by refundable health care tax credits, which ensures that low-income and rural citizens have access to sound private health care coverage.

The Bush proposal, like the more costly Kerry proposal, goes in the wrong direction. Jeff Lemieux, executive director of Centrists.Org, is probably correct to observe, "Tax credits or other public–private arrangements would be less effective for people who are very poor."[43] While it may be difficult to get poor Americans off Medicaid, the policy objective should nonetheless be to integrate poor Americans—particularly low-income working Americans—into the private health care system, not expand their dependency on Medicaid or other public health care programs. Instead, the Bush proposal:

- **Further discourages the purchase of private, family coverage among low-income families.** The first basic question is whether children, as a matter of public policy, should be separated out and treated differently from their parents. Uninsured children are invariably the progeny of uninsured parents, and public policy should focus on providing assistance to families, not merely isolated individuals or age groups. The second question is whether increased enrollment in these programs—whether of the parents or their children—is the best course of action for them in both the short and long terms. The existing professional literature shows a strong correlation between public program expansion and a decline in private coverage, a phenomenon often described as the "crowding out" effect. The result is greater and more costly dependency on the government for the delivery of health care. Policymakers should reverse course.

  Because of rising health care costs, compounded by unsound government policies, it is harder for low-income persons to secure and maintain private health care coverage. It is not surprising then that the decline in private health insurance coverage in recent years, particularly among children, has been accompanied by a rise in public-program coverage.[44]

A Better Approach. The right policy for low-income individuals and families, particularly those who are working or capable of working, is one that moves them away from dependence on government programs and mainstreams them into private health insurance whenever and wherever possible. Thus, health policy should complement, not contradict, welfare reform policy, which is primarily intended to get Americans off welfare, reduce dependency, and mainstream them into productive jobs in the general economy.

Instead of pushing more children into Medicaid and S-CHIP, policymakers should use existing program funds for expanding private family coverage, with an emphasis on the family unit. During their first term, Bush Administration officials at HHS embarked on a promising Medicaid–S-CHIP waiver program to institute innovative approaches to expand coverage options for low-income Amer-

41. Jennifer Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from the Commonwealth Fund 2002 Workplace Health Insurance Survey," Commonwealth Fund *Issue Brief,* August 2002, p. 7, at *www.cmwf.org/publications/publications_show.htm?doc_id=221528* (October 1, 2004).

42. Stan Dorn, "Towards Incremental Progress: Key Facts About Groups of Uninsured," Economic and Social Research Institute *Fact Sheet*, September 2004, at *www.esresearch.org/newsletter/facts_uninsured.pdf* (October 6, 2004).

43. Jeff Lemieux, "Senator Kerry's Health Proposal: Prospects for Bipartisanship?" Centrists.Org, August 25, 2004, at *www.centrists.org/pages/2004/08/18_lemieux_health.html* (October 6, 2004).

44. Center for Studying Health System Change, "Rising Health Insurance Costs Key to Decline of Private Coverage for Children," news release, September 14, 2004, at *www.hschange.org/CONTENT/705/* (October 6, 2004). For a full discussion of the private and public trends in children's coverage, see Peter J. Cunningham and Jim Kirby, "Children's Health Coverage: A Quarter-Century of Change," *Health Affairs*, Vol. 23, No. 5 (September/October 2004), pp. 27–38.

icans.[45] Instead of simply expanding existing public programs, which are already in desperate need of reform, the Administration should intensify its efforts to promote flexibility and encourage innovative, private coverage options at the state level. Offering families a direct subsidy for a child eligible for Medicaid and S-CHIP could easily supplement an even more generous refundable federal tax credit for low-income families. The right policy should help poor families to obtain private family insurance coverage that they could maintain throughout the course of their lives.

By financially empowering the poor through tax credits and other means, policymakers could create a viable market in which health insurers would compete with each other for new dollars based on quality and service. Newly empowered consumers could ignite an even greater demand and bring more doctors and medical personnel into areas of the nation where they are in short supply.

How the Bush Plan Would Promote Information Technology

The President's goal is to have a majority of Americans with electronic medical records within 10 years. His purpose is to make electronic health care records available to doctors and other medical professionals and to accurately record pharmaceutical prescriptions. This would, according to the White House, reduce medical mistakes and increase quality and safety for patients. To facilitate this process, the President has proposed making $100 million available in grants to "test" information technologies.[46]

Analysis. Like Senator Kerry, President Bush wants to promote the use of information technology to streamline recordkeeping and communications within the health care sector of the economy. Indeed, beyond the presidential candidates' broad proposals, there is an impressive consensus among prominent members of Congress, including Senate Majority Leader Bill Frist (R–TN) and Senator Hillary Clinton (D–NY), that upgrading communications and recordkeeping through information technology can improve the quality of medical services.[47] The degree to which these initiatives would yield significant savings is more questionable.[48]

The information technology (IT) industry is eager to provide the health care industry with the same kinds of efficiency generating and productivity enhancing technologies that it has been selling to corporate customers in other sectors for decades. Indeed, the health care industry is already rapidly adopting these technologies, and about 25 percent of hospitals will be implementing this electronic medical record system in 2006.[49] Thus, it is questionable whether any major federal effort would produce significantly greater results than those private sector efforts already underway.

One obstacle to an even more rapid adoption is that health care providers and insurers still lack sufficient free market incentives to accelerate such improvements. Until the market is transformed into one that is patient-centered and consumer-driven, doctors, hospitals, and other medical professionals will not have the same strong incentives that would otherwise exist within a free market to purchase the necessary IT systems or upgrade them to remain competitive.[50]

45. For discussion of the possibilities of HIFA waivers, see Nina Owcharenko, "How States Can Expand Private Coverage with HIFA Waivers," Heritage Foundation *Executive Memorandum* No. 846, December 16, 2002, at *www.heritage.org/Research/HealthCare/EM846.cfm*, and Sachs, "HIFA at Age Two."

46. The White House, "President George W. Bush: A Remarkable Record of Achievement," August 2004, p. 29.

47. "And while there is no consensus yet on all the changes needed, we both agree that in a new system, innovations stimulated by information technology will improve care, lower costs, improve quality and empower consumers." Senator Bill Frist (R–TN) and Senator Hillary Clinton (D–NY), "How to Heal Health Care," *The Washington Post*, August 25, 2004, p. A17.

48. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 26

49. *Ibid.*

50. See Mark A. Pearl, "Consumer-Driven Health Care and the Internet," in Regina E. Herzlinger, ed., *Consumer Driven Health Care* (San Francisco: Jossey-Bass, 2004), pp. 428–439.

How the Bush Plan Would Reform Medical Malpractice Law

The President has strongly supported medical liability reform at the federal level, arguing that this reform would speed recovery damages to patients, fairly compensate those who have been injured, and increase access to care.

The Bush proposal contains the key elements of serious medical malpractice reform. These include capping non-economic damages (such as pain and suffering) at $250,000, limiting punitive damages, providing for quick resolution of malpractice cases, restricting lump sum payments in favor of payments over time, and providing for unlimited compensation for economic damages (such as loss of income). In terms of savings, it is difficult to estimate the impact of tort reform on the health care system. According to the Lewin Group, the Bush medical malpractice proposals would reduce private health insurance premiums by about $6.8 billion over 10 years.[51]

Analysis. In many states, rising medical malpractice insurance premiums are a serious and growing problem, driving physicians and specialists to cut back on certain treatments and procedures, abandon certain fields of medicine, move to other states, or even quit medical practice entirely. Moreover, medical malpractice laws, as currently interpreted and enforced, clearly encourage physicians to resort to "defensive medicine," ordering extra tests or procedures in order to protect themselves against litigation. Although the impact of medical malpractice law on health care costs is difficult to calculate, there is little doubt that medical malpractice law contributes to premium costs.

The central problem with the Bush medical malpractice proposal is not its substance, but rather its venue. The President is proposing that Congress override state medical malpractice law—a realm of law that is reserved to the states. Congress simply does not have the constitutional authority to supersede state law.

A Better Approach. President Bush is correct in focusing the nation's attention on the medical malpractice crisis. Traditionally, however, such reforms have been left to the states, and many states, facing an immediate crisis, have already taken steps to change their policies. This is, and should properly remain, a function of the states. The President has outlined guiding principles for medical liability reform that can be a model for the states. Proactive state officials should act quickly and pre-empt federal action on this serious problem in the health care system.

How the Bush Plan Would Improve Medicaid/Medicare and Promote Long-Term Care

The President intends to crack down on the misuse of taxpayer funds in Medicaid and Medicare. This seems to be a recurrent task, spanning presidential Administrations. With a large bureaucratic federal and state system overseeing health insurance for millions of Americans, it is not surprising that Medicaid—and Medicare—are easily exploited by unscrupulous providers and vendors. Indeed the very complexity of these programs provides the kind of camouflage that invites fraud and facilitates waste. This complexity also invites mistakes, clerical errors, and increasing government audits and investigations, which frighten and discourage honest doctors and other medical professionals.

Another key problem is that formerly middle-class retirees are increasingly relying on Medicaid for their long-term care needs. Of the roughly $82 billion of Medicaid spending allocated for long-term care in 2002, 57 percent was spent on nursing home care.[52] With the rapid aging of the population, taxpayers can expect that level of spending to accelerate, imposing progressively larger burdens on the next generation of taxpayers.

51. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 12.

52. Ellen O'Brien and Risa Elias, "Medicaid and Long-Term Care," Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, May 2004, p. 9, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36296* (October 1, 2004).

Tax Breaks. The President proposes to tackle the long-term care problem through the expansion of private, long-term care insurance and by enhancing the tax benefits of family members who care for ailing senior relatives in the home. Specifically, the President is proposing a tax deduction for long-term care. He would provide for an above-the-line deduction for long-term care insurance premiums.

He is also proposing an additional tax exemption for home caregivers of family members. This would permit families caring for a loved one, such as an elderly parent, to claim that person as an additional personal exemption on their taxes

According to the Lewin Group, the long-term care insurance deduction would amount to $28.6 billion over 10 years, and the home caregiver tax exemption would amount to $33 billion over the same period.[53]

Analysis. The President's proposals would start a long overdue discussion about the enormous costs of long-term care and the grim consequences for those who do not secure private insurance to cover those costs and for the taxpayers who will foot the bill.

The President's proposal would help individuals to plan for their future health care needs. Too many Americans still do not plan for their long-term care needs, such as assisted living expenses and nursing home care. The Medicaid program has become the default long-term care plan for many Americans, not just low-income Americans. By encouraging the purchase of long-term care insurance, Americans can be protected from these costs and not forced to depend on a taxpayer-funded health care program for the last years of their life.

The President's proposal would also help families caring for their loved ones. Today, many families choose to care for their loved ones at home, instead of institutionalizing them. In the long run, this is less costly to taxpayers and provides a more stable setting for those in need.

Once again, a cautionary note is in order. The multiplication of tax breaks is an impediment to comprehensive tax reform and tax simplification. There is a tension that must be recognized and balanced by the President and Congress. While there is a need to reform and streamline the tax code, the key argument for refundable tax credits for health insurance—as opposed to relying on more tax deductions—is that the credits are targeted to low-income working people who need the most help and are designed to help them purchase affordable health coverage. In so doing, the credits expand private health coverage, improve access to quality health care, and also reduce current and future dependence on government health programs. On the other hand, tax deductions, as desirable as they may appear for certain purposes, tend to favor those who can already afford coverage and would likely (if motivated) purchase coverage anyway.

In addition to the promotion of private long-term health insurance, the President is also correct to emphasize the continuing need to weed out waste, fraud, and abuse in the system. Based on previous experience, this will remain a formidable task. However, it is even more important for federal and state policymakers to restructure Medicaid, so that those delivering care in the system become more directly accountable to the people who use it as well as the taxpayers who fund it.

A Better Approach. One promising development within Medicaid is the success of the experimental "Cash and Counseling" demonstration program. Under this program, certain disabled individuals on Medicaid are given special accounts that they use to select and pay their caregivers directly for personal care services. The initial evaluations of this approach have been positive.[54] The Medicaid Cash and Counseling demonstration was promoted

53. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 7.

54. See Leslie Foster, Randall Brown, Barbara Phillips, Jennifer Schore, and Barbara Lepidus Carlson, "Improving the Quality of Medicaid Personal Assistance Through Consumer Direction," Health Affairs *Web Exclusive*, March 26, 2003, at *content.healthaffairs.org/cgi/reprint/hlthaff.w3.162v1* (October 1, 2004), and Stacy Dale, Randall Brown, Barbara Phillips, Jennifer Schore, and Barbara Lepidus Carlson, "The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas," Health Affairs *Web Exclusive*, November 19, 2003, at *content.healthaffairs.org/cgi/reprint/hlthaff.w3.566v1* (October 1, 2004).

and expanded under the Bush Administration and this model should be replicated with other populations dependent on Medicaid for their care and services. Such a consumer-centered model would be a much more effective solution to improving access to services and purging the system of waste and abuse. It would empower patients and improve the quality of care, while preventing exploitation of these vulnerable populations by unscrupulous Medicaid providers and vendors.

Conclusion

President Bush has outlined a health policy agenda that introduces key changes in the conventional financing and delivery of health care. Chief among these proposals is the health care tax credits for the lower-income Americans to help them purchase private health coverage. If these changes take root, they have the potential to transform the health care sector. Moreover, they would expand both the personal ownership of health insurance policies and personal control over health care spending and key health care decisions.

The President has also proposed several innovative changes to the health insurance markets, most notably the provision for direct health plan competition across state lines. There is no reason why health insurance should be immune from national competition. Moreover, national competition could engender the creation of large national pools, with consequent reductions in administrative costs. The inclusion of more and more persons, particularly younger persons and families who have been previously uninsured, could also intensify a downward pressure on average claim costs.

Although the President's efforts to expand personal choice and coverage through the private sector are laudable, he is mistaken in his proposal to create favored tax treatment for high-deductible plans and new tax subsidies for small businesses that contribute to their employee's Health Savings Accounts. The right tax policy with regard to health care options is neutrality—an equal playing field for all health plans and options, without exception.

Public program expansion has accompanied an unhealthy contraction in private coverage, particularly among children. The right policy is to reverse these dynamics. Instead of expanding Medicaid, the President should find ways to mainstream low-income persons, including children, into the private health care system. Public health and welfare program expansions, coupled with declines in private coverage, are hardly a sign of progress. Rather, they indicate the size of the challenges ahead and how much more must be accomplished in transforming the health care system into one that is patient-centered and consumer-driven.

—Robert E. Moffit, Ph.D., is Director of and Nina Owcharenko is Senior Policy Analyst for Health Care in the Center for Health Policy Studies at The Heritage Foundation.