Executive Summary
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Details Matter: A Closer Look at Senator Kerry's Health Care Plan

Robert E. Moffit, Ph.D., Nina Owcharenko, and Edmund F. Haislmaier

Senator John Kerry (D–MA), the Democratic presidential candidate, is offering an expansive health plan that would cost well in excess of $1 trillion during its first 10 years of operation.

Complex and far-reaching health care proposals are invariably difficult to explain to the general public and even more difficult for Congress to enact and for the executive branch to implement. This is especially true of Senator Kerry's health plan because it is not a single, coherent plan, but rather a wide array of complex policy changes affecting public and private health care coverage. In combination, the goal of these initiatives is to address rising health care costs and expand health care coverage to millions of Americans.

Array of Initiatives. Senator Kerry's plan makes major changes in employer-based insurance and government health programs, proposes initiatives to improve quality and cut administrative costs, and offers a variety of tax subsidies and coverage arrangements to businesses and individuals. His most dramatic provision is to create a separate pool within the Federal Employees Health Benefits Program (FEHBP) called the Congressional Health Plan, which would be open to all Americans, especially the uninsured.

However, the differences in financing and risk sharing between the FEHBP and the proposed Congressional Health Plan make it extremely unlikely that the new program would work as the FEHBP does today. Instead, it is more likely to become an engine of government regulation than a model of consumer choice and competition.

Costly Complications. While Senator Kerry's plan would newly insure between 25 million and 27 million Americans, it would also incrementally expand federal control over the financing and delivery of health care. It is fraught with unintended consequences for taxpayers, employers, and workers. Specifically, the Kerry plan would:

- **Shift the cost of private health insurance to taxpayers.** The federal government would create a "premium rebate" subsidy and displace private insurance as payer of the bulk of high-end health care costs. According to the Lewin Group, the premium rebate to cover high-end health care costs would result in estimated additional federal spending of $725.7 billion over 10 years.
- **Dramatically expand Medicaid, thus crowding out private coverage options.** The Medicaid expansion alone would cost an estimated $553.1 billion over 10 years. Research shows that public program expansions historically crowd out private health insurance.

This paper, in its entirety, can be found at:
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- **Accelerate the growth of federal control over the health care system.** In order to secure government subsidies for coverage, employer-based health insurance would be required to comply with new rules. Enforcing these rules would require new monitoring requirements.
- **Impose an enormous new tax burden on Americans.** The Kerry plan is clearly expensive. Analysts at the American Enterprise Institute estimate that it would cost $1.5 trillion over the first 10 years, while the Lewin Group, one of the nation's leading econometric firms specializing in health policy, puts the 10-year price tag at $1.25 trillion. Professor Kenneth Thorpe, a prominent health policy analyst at Emory University, estimates that it would cost $653 billion over 10 years.

  In any case, it is unlikely that Senator Kerry's proposed tax and spending increases, including tax increases on American families making over $200,000 per year, would enable him to cover the costs of his health care program. Therefore, taxpayers would have to pay even higher taxes to finance the plan.

The Unfinished Business of Reform. The health care system needs a systemic transformation. Although the Kerry plan represents an impressive commitment of taxpayer dollars to expand coverage, it would fall short in transforming the health insurance markets or making patients the key decision makers in the health care system. As Joseph R. Antos, a senior health policy analyst at the American Enterprise Institute, has observed, "Taking a lesson from previous reform efforts that failed to gain popular support, the Kerry agenda stays carefully within the framework of public and private health insurance as we know it today."

In effect, Senator Kerry's plan would reinforce the major institutions that comprise the health care status quo. Employers would get new federal subsidies, even for people who are already insured. As John C. Goodman, president of the National Center for Policy Analysis, has noted, nine out of 10 dollars of Senator Kerry's package of health care spending would go directly to employers, insurance companies, and state governments—not individuals.

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Senator John Kerry (D–MA), the Democratic presidential candidate, is offering an expansive plan to increase insurance coverage and control health care costs. Based on the preponderance of recent empirical analyses, Senator Kerry's plan would cost well in excess of $1 trillion during its first 10 years of operation.[1]

Complex and far-reaching health care plans are invariably difficult to explain to the general public and even more difficult for Congress to enact and for the executive branch to implement. This is especially true of Senator Kerry's health plan, because it is not a single, coherent plan, but rather a wide array of complex policy changes affecting public and private health care coverage.

Array of Initiatives

Senator Kerry's proposal includes:

- Changes in the employment-based health insurance system, tax credits and subsidies, and federal assumption of the bulk of high-end catastrophic health costs;
- Adoption of new rules and policies for the provision of prescription drugs;
- Changes in the laws governing medical malpractice and patients' rights;
- Provision of federal incentives to improve health care quality;
- Adoption of information technology to curb administrative health care costs;
- Strengthened safety net organizations;

Talking Points

- Senator Kerry's health care plan would insure between 25 million and 27 million currently uninsured Americans at a cost well over $1 trillion during its first 10 years.
- Because Senator Kerry's proposed tax increases are unlikely to cover the costs of his health care plan, taxpayers would likely face additional significant tax increases.
- Massive subsidies to employers would be conditioned on their acceptance of new government requirements relating to coverage and contributions to health insurance, and government officials would have to monitor and enforce these new requirements.
- Given the Kerry proposal's insistence on the taxpayers' assumption of risks and costs, as well as its strong potential for adverse selection, the proposed Congressional Health Plan within the Federal Employees Health Benefits Program would likely become an overregulated, government-controlled system of limited competition. It would transform the FEHBP into a program very different from the one that exists today.

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- Promotion of disease management and health promotion initiatives;
- Expanded public coverage for children and adults through Medicaid and the State Children's Health Insurance Program (SCHIP), as well as changed federal and state responsibilities;
- Creation of health care tax credits and subsidies to make coverage more affordable; and
- Opening the Federal Employees Health Benefits Program (FEHBP) to uninsured Americans and employers through a separate pool.[2]

Taken together, these initiatives are expected to expand health coverage for approximately 27 currently uninsured million persons.[3]

Tackling Tax Policy. A fundamental weakness of the health care system is the outdated and inequitable tax treatment of health insurance, which ties access to health insurance to the workplace. Refundable tax credits, which have gained broad support among both liberals and conservatives, are an efficient way to target assistance to those in need. If implemented properly, health care tax credits could also lay the foundation for transforming the health care system and creating new dynamics in which consumers control key health care decisions, particularly the choice of health plans and benefits.

Commendably, Senator Kerry includes tax credits in his plan as a way to make health care coverage more affordable. However, many of the crucial details of these credits and other key provisions of his proposal (and how they would be implemented) remain unclear.[4]

Value of the FEHBP. The Federal Employees Health Benefits Program is the popular and successful health insurance program that provides coverage to Members of Congress, federal workers, and retirees. Senator Kerry has made direct access to the FEHBP by individuals and small businesses a key part of his effort to expand coverage.

While the FEHBP can be a useful *model* for reform based on consumer choice and competition, however, there are some serious practical problems with relying on the FEHBP itself, even with separate pooling arrangements. A number of these problems arise from the major differences between the federal workforce and the uninsured population.

Costly Complications. While the Senator's plan would clearly broaden coverage, a closer review reveals that it would incrementally expand federal control over the financing and delivery of health care and that it is fraught with unintended consequences for taxpayers, employers, and employees. Specifically, the Kerry plan would:

- **Shift the high cost of private health insurance to taxpayers and increase these obligations over time.** The Kerry health plan envisions the taxpayers picking up the high-

1. For example, see John Sheils and Randall Haught, "Bush and Kerry Health Care Proposals: Cost and Coverage Compared," Lewin Group, September 21, 2004, at *www.lewin.com/NR/rdonlyres/e3atrfxcgu4ge5exrxwbqcespnrtjpckiofchqjmc47ucccnysofc25cdom67s42ng2b446i7dnfyj/LewinAnalysisCandidatesProposals.pdf* (September 30, 2004); 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); John C. Goodman and Devron M. Herrick, "The Case Against John Kerry's Health Plan," National Center for Policy Analysis *NCPA Study* No. 269, September 10, 2004, at *www.ncpa.org/pub/st/st269* (September 30, 2004). Professor Kenneth Thorpe of Emory University offers a more modest ten year cost estimate of $653 billion. See Kenneth Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," Emory University, August 2, 2004, at *www.sph.emory.edu/hpm/thorpe/kerry-8-23-04.pdf* (September 30, 2004).
2. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," at *www.johnkerry.com/issues/health_care/health_care.html* (September 16, 2004).
3. *Ibid.*, p. 10. The Lewin Group estimates the reduction in the number of uninsured under Kerry's plan at 25.2 million, or 51 percent. See Sheils and Haught, "Bush and Kerry Health Care Proposals," p. vi.
4. As Jeff Lemieux, executive director of Centrists.Org, notes, "Campaign proposals are designed to make political points and illustrate conceptual policies. But the cliché that 'the devil is in the details' is true." Jeff Lemieux, "Senator Kerry's Health Proposal: Prospects for Bipartisanship?" Centrists.Org., August 25, 2004.

end costs of patients and employers in private insurance. However, the economic and political dynamics of this proposal would surely undermine existing incentives to contain costs and likely result in even higher taxpayer obligations and health care spending over time.

- **Expand Medicaid and other public programs and crowd out private coverage options.** By expanding eligibility for these programs, the Kerry plan would make millions of Americans dependent on the government for the financing and delivery of health care services. It would also displace existing private coverage to some degree and discourage future private coverage options for Americans who might otherwise be able to secure the coverage of their choice through an alternative health care tax credit program.
- **Accelerate the growth of government control over the health care system.** To implement, manage, and enforce the wide array of health initiatives put forth in the Kerry plan, the role of the federal government would expand. It not only would assume a more direct financial responsibility for coverage, but also would impose even heavier regulation on the already overregulated health care sector. This would increase costs.
- **Impose an enormous new tax burden on Americans.** Professor Kenneth Thorpe of Emory University has estimated that the Kerry plan would cost $653 billion over 10 years.[5] These health policy initiatives would be financed by repeal of various tax cuts enacted during the first term of the Bush Administration. However, the latest independent cost estimates of the Kerry health plan are more staggering, ranging from $1 trillion to $1.5 trillion for the first decade of operation.[6] Given these new cost estimates, it is highly unlikely that the Senator's proposed tax increases would cover the cost of his health plan, and taxpayers would likely face additional significant tax increases.

The health care sector of the American economy needs a major systemic transformation that would result in a new patient-centered, consumer-driven system. Although an impressive effort to address several pressing problems, the Kerry plan falls short of transforming the health insurance markets or making patients the key decision makers in the health care system.[7]

As Joseph R. Antos, senior health policy analyst at the American Enterprise Institute, has observed, "Taking a lesson from previous reform efforts that failed to gain popular support, the Kerry agenda stays carefully within the framework of public and private health insurance as we know it today."[8] John Goodman, president of the National Center for Policy Analysis, notes that, in expanding existing third-party payment arrangements, 90 percent of Senator Kerry's proposed spending would go to employers, insurance companies, and state government—not individuals.[9]

How Senator Kerry Would Change Employment-Based Health Insurance

Senator Kerry has outlined key initiatives designed to control health care costs and expand coverage,[10] but his most far-reaching proposals center on his initiatives to change the risks of employment-based health care coverage.

5. Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," p. 1.
6. Antos *et al.*, "Analyzing the Kerry and Bush Health Proposals," p. 1; Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 5; Goodman and Herrick, "The Case Against John Kerry's Health Plan."
7. For a bipartisan discussion of how the current health care system should be changed, see Robert E. Moffit, Ph.D., Daniel "Stormy" Johnson, M.D., Stuart M. Butler, Ph.D., Stan Dorn, J.D., John Goodman, Ph.D., and Kenneth Thorpe, Ph.D., "A Vision for Health System Change," Heritage Foundation *Lecture* No. 848, August 12, 2004, at *www.heritage.org/research/healthcare/hl848.cfm*.
8. Joseph Antos, "Kerry, Bush, and the Uninsured," American Enterprise Institute *Health Policy Outlook*, September–October 2004, p. 3.
9. John C. Goodman, "Kerrycare," *The Wall Street Journal*, August 26, 2004, p. A12.

Premium Rebate Pool. Senator Kerry would have the federal government assume 75 percent of the costs for employer-based health claims that exceeded certain thresholds, starting at $30,000 in 2006 and reaching $50,000 in 2013.[11]

To qualify for this "premium rebate," employers would be legally required to (1) provide health care coverage to all their employees; (2) adopt disease management programs in their health plans; and (3) pass along savings from the rebate to employees. Premium savings are estimated at 10 percent, or $1,000 for a standard family health plan.[12]

According to the Lewin Group, the employer (and non-group) premium rebates would amount to $725.7 billion in federal spending over the first 10 years of the program.[13]

Analysis. The employer premium rebate proposal would no doubt appeal to some major employers and health insurance executives. They would have an opportunity to off-load the high costs of high-risk enrollees onto the taxpayers.

In other words, the proposal would be an engine of major cost shifting. Jeffrey Petertil, an independent consulting actuary, says that the proposal would make insurance premiums more "predictable," but it would be costly and would "supplant" the reinsurance market, "so it is a bigger step toward national health insurance than may be evident from a quick read of the idea."[14] In any case, billions of dollars of additional cost shifting in the health care sector would not add one cent of value to patient care.[15]

The Kerry proposal would also introduce new dynamics into employer-based health insurance that would directly expand federal control over benefit offerings. The substance of this approach, as Joseph Antos has observed, is a "voluntary mandate," meaning that employers must comply with the new rules in order to qualify for the generous taxpayer subsidies.[16] Specifically, this approach would:

- **Push employers toward a standardized government benefit package.** By establishing a government reimbursement for high-cost claims, the Kerry plan would likely lead the government to establish a list of "qualified expenses" used to track claims. Employers, for the sake of ease, would likely adjust their benefit packages to conform with the government's list of qualified expenses, thus creating a default standardized benefit package for employer-based coverage and subjecting the plans and employers to unending government regulatory requirements.
- **Pass costs on to American taxpayers.** The Kerry plan would shift the costs of caring for the highest-cost privately insured patients directly onto the taxpayer. With the government assuming the financial risk of these patients, the Kerry initiative negates the very purpose of private insurance, which is designed to protect against catastrophic costs. It also negates the function of private group health insurance, which is designed to spread risk across a large number of people. As Antos further observes, "It does not add significantly to the financial protection against risk already available to employers in the insurance market."[17]
- **Discourage cost-conscious behavior of actors in the health care system.** By shifting the high costs to the taxpayers, the Kerry plan

10. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Coverage Affordable to Every American," pp. 1–6.
11. *Ibid.*, p. 2.
12. *Ibid.*, pp. 1–2.
13. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 8.
14. "Presidential Prescriptions for Our Ailing Health Care System," *Contingencies*, September/October 2004, p. 28.
15. On the flaws of the current health insurance markets and the problem of cost shifting, see Michael E. Porter and Elizabeth Olmstead Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004, pp. 65–76.
16. Antos, "Kerry, Bush, and the Uninsured," p. 3.
17. *Ibid.*

would reduce the incentive for individuals, employers, insurers, and providers to be prudent users or managers of health care services. If the taxpayer will pick up the bulk of high-end costs, those in the private sector have less reason—or incentive—to worry about cost growth. Helen Darling, president of the National Business Coalition on Health, notes that, once a patient reaches the threshold at which the taxpayer funding kicks in, "there's no reason for anyone to pay attention to costs."[18] Therefore, instead of controlling health care costs, this proposal is likely to have the exact opposite effect.

The proposal would also set in motion undesirable political dynamics. Clearly, it would create political incentives to lower the dollar threshold at which the taxpayer funding kicks in. Alternatively, it could also induce political pressures to reduce or eliminate the remaining private-sector cost sharing. Why should employers, employees, and health insurers be satisfied with paying 25 percent when they could lobby to pay only 20 percent, 10 percent, or zero percent? The political dynamics of lower cost sharing—accompanied by standard "something for little or nothing" political appeals—are normally unstoppable, regardless of which party controls Congress. Costs would explode.[19]

- **Introduce complex implementation problems.** The administrative burden placed on both the employers and the government to track and qualify expenses would be daunting. Moreover, guaranteeing that cost and premium savings are passed down directly to individual employees, presumably through government audits, would be complex, difficult, and intrusive. Federal agencies and departments, such as the Centers for Medicare and Medicaid Services, struggle mightily in handling such detailed and tedious jobs within the framework of well-established government health programs.[20] Tracking Medicare beneficiary spending in the 2006 implementation of the Medicare drug benefit will give Americans the flavor of the task ahead. It is certain that these new and complex administrative tasks, applied to private-sector insurance, would prove to be an enormous managerial challenge to federal officials and a new burden on employers.

A Better Approach. Rather than having the government assume catastrophic health care costs, the federal and state governments should assist private insurers in setting up catastrophic claims reinsurance pools. Under such a model, all insurers in a state or region would cede their catastrophic claims to the pool, and the cost of the pool would then be funded out of a per-covered-life assessment on all insurers. In that way, the burden of high-cost cases would be spread evenly among all carriers and insurers, who would have strong economic incentives to manage these cases, and not simply dumped on the taxpayer.

How Senator Kerry Would Make Prescription Drugs More Affordable

The cost of prescription drugs is a topic that resonates with Americans, especially those who do not have prescription drug coverage. Beyond easing importation of drugs from Canada, Senator Kerry proposes three major policy initiatives aimed at making prescription drugs more affordable.

First, the Senator would change the rules governing Prescription Benefit Managers (PBMs). He would require PBMs that do business with the federal government to disclose any "savings" received from manufacturers and from bulk purchasing.[21]

Second, the Senator would change the patent laws governing pharmaceuticals by eliminating so-called

18. Sarah Lueck, "Businesses Are Wary of Kerry Health Plan," *The Wall Street Journal*, July 26, 2004, p. A4.

19. Soaring costs would doubtless encourage federal officials to resort to price controls or access controls, or tougher standards for "medical necessity" and "appropriateness," thereby hurting precisely the persons the plan is designed to help.

20. For an indication of the managerial problems that continue to plague Medicare, see Robert E. Moffit, "Congress Should Think Twice About Allowing the Medicare Bureaucracy to Manage a Drug Benefit," Heritage Foundation *Backgrounder* No. 1583, September 9, 2002, at *www.heritage.org/Research/HealthCare/bg1583.cfm*.

loopholes in patent law in order to allow less expensive generic drugs to enter the market faster.[22]

Third, the Senator would encourage states to negotiate discounted rates for prescription drugs, similar to Medicaid discounted rates, for their citizens and would devise incentives for states to implement efficient contracting for better rates.[23]

Analysis. The Kerry prescription drug proposals would have several undesirable consequences. Specifically, they would:

- **Restrict the ability of PBMs to continue to negotiate discounts for consumers.** Price disclosure at the wholesale level would result in producers offering less generous discounts to retailers. If a producer does not know the discounts that its competitors are offering the retailer, it has an incentive to offer the largest discount that it can afford without harming its own profitability. However, if the producer knows the wholesale prices offered by its competitors to a particular retailer, the producer has an incentive to "shadow price" (i.e., offer only a slightly more generous discount than its nearest competitor) rather than offer the largest possible discount while maintaining profitability. Thus, if the government requires disclosure of wholesale prices, the discount levels offered by the manufacturers to the PBMs would erode, with the eventual result that consumers would pay higher prices for prescription drugs.

  This approach could also restrict the ability of PBMs and pharmaceutical companies to have a private contractual relationship related to pricing and incentives. This information would alter the nature and/or structure of those agreements. If required to make their private concessions available to the government and the public, pharmacy networks and drug manufacturers might be less willing to offer terms as generous as those they currently offer. Policymakers should resist efforts to restrict the ability of PBMs to engage in private contracts and should instead allow competition to continue bringing discounted prices to consumers.

- **Possibly disrupt carefully constructed patent law.** While the patent laws may not be perfect, Congress labored to create the proper balance between patented drugs and generic drugs. This balance ensures that innovative drug manufacturers are rewarded for their efforts and that generic drug manufacturers can enter the market in a timely and fair fashion. It is imperative that policymakers proceed cautiously when changing existing patent law so that they do not destroy this balance in favor of either patented or generic drugs.

- **Encourage state governments to set prices for prescription drugs.** Allowing states to extend the Medicaid rebate program to larger populations, as implied by the Kerry plan, would induce manufacturers to reduce or eliminate discounting for both Medicaid and other purchasers—or even to raise prices further. The net effect would be that Medicaid would end up paying more for drugs.

  If states were also allowed to apply the Medicaid formulary to those purchases, they would effectively have the ability to demand specific prices from drug makers as a condition of sale in their states. This, in effect, would result in direct government price controls for prescription drugs, enforced by denying patients access to drugs if manufacturers do not agree to a state's terms.[24]

A Better Approach. New government rules, including regulations, on prescription drugs may prove politically popular in the near term, but such

21. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 3.

22. *Ibid.*

23. *Ibid.*

24. For further discussion, see Nina Owcharenko, "Why Maine Rx Is the Wrong Model for Improving Access to Prescription Drugs," Heritage Foundation *WebMemo* No. 282, May 28, 2003, at *www.heritage.org/Research/HealthCare/wm282.cfm*, and Derek Hunter, "Government Controls on Access to Drugs: What Seniors Can Learn from Medicaid Drug Policies," Heritage Foundation *Backgrounder* No. 1655, May 27, 2003, at *www.heritage.org/research/healthcare/bg1655.cfm*.

measures ultimately lead to government officials deciding which drugs are made available.[25] Policymakers should focus on ensuring that individuals have access to health insurance policies that integrate prescription drug coverage into the overall health care package and that allow the private sector to negotiate prices and discounts, as PBMs currently do. Furthermore, individual consumers should have access to a variety of coverage options from which they can select the health plans that best suit their individual health care needs.[26]

How Senator Kerry Would Change Medical Malpractice Law

Senator Kerry proposes a series of changes in medical tort law, and other changes in the legal system,[27] that he believes would improve the conditions for both doctors and patients.

The Kerry medical liability proposal would require a specialist to determine whether a "reasonable claim exists" before allowing an individual to bring a case and would impose mandatory sanctions for improper, unwarranted cases.[28] Under the Kerry plan, states would be required to establish non-binding mediation before permitting a case to go to trial.[29] Senator Kerry would also oppose awards of punitive damages unless there was "proof of intentional misconduct, gross negligence, or reckless indifference to life."[30]

According to the Lewin Group, Senator Kerry's medical liability proposals would reduce private health insurance premiums by about $7 billion over a 10-year period.[31]

Analysis. The Kerry plan includes a number of positive proposals for changing medical malpractice law, particularly the restrictions on punitive damages, the establishment of mediation, and measures to discourage frivolous or weak cases from going to trial.

The Kerry approach, however, lacks the core features of the most aggressive and successful medical malpractice reforms that have been adopted in the states, most importantly the capping of non-economic damages. Professional medical societies strongly agree such major changes in medical malpractice laws are essential to maintaining patient access to quality medical care.[32]

A Better Approach. Given the gravity of the problem, many states already have enacted serious medical malpractice reforms. The Senator's proposals are a valuable contribution to the policy debate, but certain basic features—such as capping non-economic damages—are keys to successful reform, as illustrated in California. States should be encouraged to continue these efforts.

How Senator Kerry Would Improve Health Care Quality

Senator Kerry proposes a series of initiatives to deal with problems of quality in health care delivery. For instance, the Senator would provide a "quality bonus" for doctors, medical specialists,

25. As Jeff Lemieux notes, "Government price setting in health care—however indirect—can have long term negative side effects that consumers in search of instant gratification may not perceive or comprehend." Lemieux, "Senator Kerry's Health Proposal."
26. On this point, see Edmund F. Haislmaier, "Compromising Quality: The High Cost of Government Drug Purchasing," Heritage Foundation *Backgrounder* No. 1764, May 25, 2004, at *www.heritage.org/research/healthcare/bg1764.cfm.*
27. For example, the Senator would reintroduce "patients bill of rights" legislation, providing for new avenues of litigation against HMOs. According to the Lewin Group, this proposal would increase private health insurance premium costs by an estimated $108.9 billion over 10 years. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 13.
28. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," pp. 3–4.
29. *Ibid.*, p. 4.
30. *Ibid.*
31. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 12.
32. See John C. Nelson, M.D., M.P.H., "Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of Medical Liability Insurance," testimony before the Subcommittee on Human Rights and Wellness, Committee on Government Reform, U.S. House of Representatives, October 1, 2003, at *www.ama-assn.org/ama1/pub/upload/mm/399/mlr_dying_for_help.pdf.*

and health plans.[33] The quality bonus proposal would (1) provide financial incentives to encourage providers and purchasers to make changes and meet benchmarks to improve quality, (2) establish a reward system for health care organizations and physicians that implement modern information systems, (3) provide financial incentives to computerize prescribing systems, and (4) encourage immediate reporting of patient injuries and errors.[34]

Analysis. Positive financial incentives such as "quality bonuses" are invariably superior to negative incentives, such as financial penalties, price restrictions, or market exclusions. The computerizing of prescriptions promises to reduce the number of medication errors, and the "immediate reporting" of errors would certainly benefit patients, improve communications among doctors and nurses, and contribute to an overall improvement in patient care. Needless to say, enhanced communication among providers, doctors, specialists, and nurses would improve even more in an atmosphere in which the constant threat of malpractice litigation is significantly reduced.

The crucial policy issue is whether improvements in quality will come within the framework of an open system governed by consumer information and consumer choice—in which patient advocacy is robust and financial incentives naturally follow quality improvements—or through a new regulatory regime of imposed government standards.

On this point, Senator Kerry's approach raises several concerns. The Senator's proposal could:

- **Put the federal government in charge (eventually) of defining and enforcing quality.** While making up-to-date information on medical services available is clearly desirable, the danger lies in the power that the government could exercise in its implementation and its impact on the delivery of care. This revolves around potential reimbursement rules for medical services. Details matter.

  For the government to pay plans and providers for "quality improvements," it would first need to determine which quality improvements qualify for the bonuses. Quality in health care can be broadly defined as securing the right diagnosis for the right treatment at the right time. Beyond this broad generalization, it is not always easy, even for medical authorities, to determine what constitutes quality of care in any given case. Peer-reviewed medical journals and a rich body of professional literature focus precisely on these issues.

  Government introduces a new dynamic. When government plays a role, the quality issues are no longer confined simply to medical judgment, even when government officials are working closely with medical experts. Once government officials become involved in the process, there is a natural evolution toward uniformity in the application of standards. Standardized "quality" measures will likely emerge from government officials through a government decision-making process. The inevitable result would be a set of government-sanctioned quality standards. It is impossible to separate the policy process from political considerations.

- **Link future quality improvement innovations to the federally regulated incentive payment structure.** Establishing an incentive-and-reward payment system for quality might actually retard future innovation. Medical science and the resulting insights into health care "best practices" are evolving at a much faster rate than any government bureaucracy burdened by rulemaking and due process requirements could ever hope to match. Therefore, as the government lags in its ability to keep up with the latest quality innovations, so will its payments. This lag in payments will reduce the incentive for providers and purchasers to deviate from the government status quo.

  The likely results would be that providers and purchasers would be more dependent on the

33. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 4.

34. *Ibid.*, pp. 4–5.

incentive and reward payments and would have less flexibility in their practice of medicine and that the patient would be cared for through a bureaucratic model instead of the far more desirable doctor–patient model. At the same time, such a system would entrench standards that are based on obsolete understandings of the effectiveness of various medical treatments. Patients could end up receiving care based on perennially outdated models of medicine.

A Better Approach. While some incentive structures may be logical, policymakers should be wary of replacing free-market competition with government subsidies that remove the natural market incentives to improve care and adapt to patient demand. The better approach is to foster the creation of multiple, private standard-setting organizations. These can gather and disseminate solid information quickly and efficiently, updating best practices, in a fashion that is far more responsive than the standard and painfully sluggish government regulatory regime, such as the regulations administered by Medicare and Medicaid.

The key ingredient is the ability of patients to act directly on that information by controlling the flow of dollars in the system. Empowering patients with more control over their health care financing will bring to the fore the natural incentives that all patients have to receive the best quality care, which in turn will spur providers and insurers to develop, implement, and publicize best practices on their own and in real time.

In the end, better reporting of adverse medical events requires medical malpractice reform. No system designed to identify and correct medical errors will work unless those who report the information (providers) are first shielded from having it later used against them in a court case. Without such reforms, it will simply be impossible to change the system from one that focuses on punishing past mistakes to one that focuses on preventing the reoccurrence of those mistakes.

How Senator Kerry Would Curb Unnecessary Health Care Costs

A key problem in health care today is that too many dollars flowing into the system are wasted, lost to inefficiency, or lost to a variety of time-consuming activities unrelated to patient care, including the amount of time and money that is lost to third-party administration.

However, a variety of activities, beyond the administrative costs of marketing private health insurance or the management of care by health insurance officials, affect cost. They include the proliferation of litigation, the administration of claims for routine medical services in third-party payment arrangements, and compliance with an ever-growing body of government rules and regulations in which costs often outweigh benefits. In recent testimony to the Joint Economic Committee, Christopher Conover, professor of economics at Duke University, estimated that excessive government regulation, on the basis of a cost-benefit analysis, costs the health care system $128 billion annually.[35]

Senator Kerry recognizes the systemic inefficiency of existing arrangements and outlines several policy initiatives to reduce these costs.

First, the Senator would establish a "technology bonus,"[36] but the proposal lacks sufficient detail to determine precisely how it would work. While the proposal does not specifically describe how the bonus system would operate, it would focus policymakers' attention on implementing various technologies. The technology bonus would (1) create private electronic records for all Americans, (2) computerize government health care transactions, and (3) require insurers doing business with the federal government (i.e., Medicare, Medicaid, and the FEHBP) to adopt the computerized transaction system.[37]

35. Christopher Conover, Ph.D., "Health Care Costs and the Uninsured," testimony before the Joint Economic Committee, U.S. Congress, May 13, 2004, p. 11, at *jec.senate.gov/_files/ConoverTestimony051304.pdf* (September 30, 2004).

36. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 5.

Second, the Senator includes initiatives to "help strengthen safety net" institutions by investing in capital improvements and "service expansions." The Senator believes that these investments, plus his other access proposals, would cover 95 percent of all Americans.[38] They would also generate savings by reducing uncompensated care.[39]

Third, again without much detail, Senator Kerry envisions a government role to "disseminate best practices for disease management and health promotion, encourage exercise, and invest in preventive care."[40]

Analysis. Few details characterize Senator Kerry's safety-net "investments," and regular exercise, preventive care, good health, and disease management are desirable things to promote. Theoretically, improved use of technology—as well as the promotion of more efficient health care delivery—would reduce administrative costs and reduce errors.

But Senator Kerry's commendable efforts to focus on reducing costs by adopting technology improvements and promoting efficiencies in care delivery are also short on details. Much would depend on how these initiatives are implemented. At the same time, the very breadth of these recommendations opens up a wide range of possibilities as to how these goals would be accomplished, including the potential imposition of burdensome additional regulation or new government spending. Health care costs, including compliance and transactional costs, could increase—precisely the opposite of what the Senator's proposal is intended to accomplish.

A Better Approach. Beyond existing efforts to integrate better information technology and delivery systems, policymakers should be mindful of the powerful role of consumers in creating demand for modernization in technology and care delivery. With a market-driven health care system, consumer demand for quality information and efficiencies would force providers to adopt the necessary information technology improvements to remain competitive, thereby making these improvements broadly available to consumers.

Much of the same holds true for disease management and preventive care measures. Efforts to incorporate these components into health care delivery are continuing, but they will intensify once patients are financially rewarded for collaborating directly with providers to stay healthy when possible and better manage their own care when necessary.[41]

Senator Kerry's "New Compact" to Cover Adults and All Children

Senator Kerry proposes several changes in the scope of eligibility for public health programs, particularly Medicaid. He also advocates a number of administrative changes in the Medicaid program, which is administered by the states and supervised by the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services. Under this specific initiative, Senator Kerry expects to enroll 18 million currently uninsured children and adults in public health coverage.[42]

The New Compact. Under the New Compact, the federal government would assume the full cost of the estimated 20 million children enrolled in Medicaid, and states must agree to (1) expand eligibility and enroll all eligible children up to 300 percent of the federal poverty level (FPL, $56,550 for a family of four); (2) expand cover-

37. *Ibid.*

38. *Ibid.*, p. 6.

39. *Ibid.*, p. 5.

40. *Ibid.*, p. 6.

41. For a discussion of the experience of consumer-directed health plans, see Grace-Marie Turner, "New Studies Show Consumer-Directed Care Reduces Costs and Improves Access," Galen Institute *Health Issues*, July 21, 2004, at *www.galen.org/fileuploads/New_Studies.pdf* (September 30, 2004).

42. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 6.

age to working parents of children eligible for public coverage up to 200 percent of the FPL ($37,700 for a family of four), who would receive an enhanced federal matching contribution; and (3) agree to cover childless adults up to the FPL ($9,310 for an individual).[43]

Senator Kerry would also make several administrative changes in public program enrollment. He proposes instituting automatic public coverage enrollment for children in schools, requiring states to adopt a 12-month continuous coverage policy that would allow individuals to remain on public coverage for an entire year regardless of a change in their eligibility status, and placing "eligibility workers" in community health centers to qualify and enroll families in public coverage.[44] Senator Kerry also proposes removing the five-year waiting period for legal-immigrant pregnant women and children to qualify for public coverage and allowing disabled children to remain on public coverage after their parents return to work.[45]

According to the Lewin Group, Senator Kerry's Medicaid initiative would cost $553.1 billion over 10 years.[46]

Analysis. The Kerry plan directly increases government responsibility for health care coverage for more Americans, expanding public coverage up the income scale and well into the middle class. The policy, in effect, is a retreat from the more desirable goal of enabling all Americans, including lower-income working families, to gain access to superior private health care coverage, which most uninsured Americans want for themselves. Specifically, the Kerry plan would:

- **Create greater dependency on a troubled government-run health care system.** This includes Medicaid, SCHIP, or both. States are already struggling to maintain and manage their public health programs, especially Medicaid. Most states have adopted a variety of cost-containment strategies in order to rein in program costs. Especially in Medicaid, states have turned to cutting already low provider payments and limiting access to prescription drugs,[47] both of which will undoubtedly affect quality and access to care. In SCHIP, many states have stopped outreach efforts, and some states have cut eligibility or restricted benefits in response to budget issues.[48]

  Medicaid in particular is in serious trouble. Physician reimbursement is low, and a lot of doctors are not taking new Medicaid patients. While the federal government would assume responsibility for covering children in middle-class families, under the Kerry plan, the states would still struggle to serve a growing number of elderly and disabled. The Kaiser Family Foundation reports that while the elderly and disabled are only 25 percent of enrollees, they account for 70 percent of Medicaid spending.[49] The Kerry proposal does little to reform Medicaid; it only increases its huge cost.

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43. *Ibid.*, pp. 6–7.

44. *Ibid.*, p. 6.

45. *Ibid.*, p. 7.

46. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 8.

47. Vernon Smith, Rekha Ramesh, Kathleen Gifford, Eileen Ellis, Victoria Wachino, and Molly O'Malley, "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, January 2004, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30453* (September 30, 2004).

48. Vernon K. Smith, Ph.D., David M. Rousseau, M.P.H., and Molly O'Malley, M.P.P., "SCHIP Program Enrollment: December 2003 Update," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, July 2004, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44443* (September 30, 2004).

49. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid: Fiscal Challenges to Coverage," *Policy Brief*, August 2003, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=31732* (September 30, 2004).

- **Crowd out existing private coverage options.** Research shows that such public program expansions, such as Medicaid expansions, have crowded out private insurance coverage, inducing employers to drop those eligible for public coverage.[50] For example, David Cutler of Harvard University and Jonathan Gruber of the Massachusetts Institute of Technology found that Medicaid expansions led to a 15 percent decline in private insurance among the affected populations between 1987 and 1992.[51] Likewise, Urban Institute researchers Lisa Dubay and Genevieve Kenny found that among pregnant women with incomes between 100 percent and 185 percent of poverty, Medicaid coverage was associated with a 52 percent decline in employer-sponsored coverage.[52]

A Better Approach. The best health care policy for low-income individuals and families is not to create greater dependency on the government, but to help mainstream them into private health insurance, which the majority of Americans enjoy today. In this respect, Medicaid policy should track welfare policy with the objective of moving people off government-run public health programs and helping them to obtain superior private health care coverage for themselves.

Policymakers should also have greater flexibility to restructure and improve service for those who are currently enrolled. For example, they should aggressively pursue direct subsidies, such as vouchers, to help lower-income individuals and families obtain private health coverage. Policymakers should also consider integrating and expanding consumer-directed models into these health programs. Recently, the potential of this approach has been powerfully demonstrated by the success of Medicaid's experimental Cash and Counseling programs.[53]

How Senator Kerry Would Expand Coverage Through Tax Credits and Subsidies

Senator Kerry has also proposed a series of initiatives to expand coverage for individuals and families, including tax credits and/or subsidies to individuals and small businesses and giving individuals and businesses access to the Federal Employees Health Benefits Program.

Using Tax Credits and Subsidies. Senator Kerry proposes to provide a complex array of tax credits and subsidies to make health care coverage more affordable for Americans. For small businesses and their employees, the Kerry plan would provide a refundable tax credit worth up to 50 percent of the cost of coverage.[54] For individuals without coverage, the Kerry plan would provide assistance for those costs above 6 percent of an individual's income.[55] To assist those who have lost their jobs, unemployed individuals would receive a 75 percent tax credit "to assure [that] workers can keep their health insurance when they are between jobs."[56] Individuals close to retirement (those between ages

50. Antos, "Kerry, Bush, and the Uninsured," p. 5.
51. David Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, Vol. 16, No. 1 (January/February 1997), pp. 196–198, at *content.healthaffairs.org/cgi/reprint/16/1/194* (September 30, 2004).
52. Cited in Rick Curtis and Anne Page, "Improving Health Care Coverage for Low Income Children and Pregnant Women: Public and Employer Financed Coverage Relations," Institute for Health Policy *Solutions*, December 17, 1996, p. 10.
53. For a discussion of the Cash and Counseling program, see 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 13, 2003, at *content.healthaffairs.org/cgi/reprint/hlthaff.w3.566v1* (September 30, 2004), and 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 23, 2003, at *content.healthaffairs.org/cgi/reprint/hlthaff.w3.162v1* (September 30, 2004).
54. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 9.
55. *Ibid.*
56. *Ibid.*, p. 10.

55 and 64) would also receive a 25 percent tax credit for the cost of their health care.[57]

Together, according to the Lewin Group, these credits would total $384.9 billion over 10 years.[58]

As a major vehicle for the tax credit policy, Senator Kerry also proposes opening the Federal Employees Health Benefits Program—the plan that serves Members of Congress, federal employees, and retired federal workers—to small and large businesses and to individuals through a special pooling arrangement.

Analysis. Health care tax credits, which have gained broad bipartisan support over the years, can make health care coverage more affordable. In that respect, the Senator's proposal is commendable. Nonetheless, a few observations are in order:

- **Tax credits targeted at employer-sponsored coverage are misguided and discourage the evolution of a consumer-oriented health care system.** Senator Kerry's proposal to give tax credits to small businesses "and their employees" misses the point of tax credit policy. The point is to expand personal choice, not the options of employers.

  Today's tax code discriminates against those who purchase their coverage outside the workplace because individuals who obtain coverage through their workplace already receive a tax benefit insofar as the value of the health plan is not included as part of the employee's taxable income. In 2004, federal tax breaks alone are expected to be $188 billion.[59] However, an individual that purchases coverage outside the workplace must use after-tax dollars to do so. Tax credits are a tool to help level the playing field for those individuals who do not have employer-sponsored coverage, not a way to make employer-sponsored coverage more generous. Tax credits should be used as an efficient way to assist individuals who purchase coverage outside the workplace.

  Second, while refundable tax credits are an efficient way to distribute assistance to individuals in need, targeting them to small businesses is not. Businesses, both large and small, already get unlimited tax breaks for offering health insurance coverage. Thus, the Kerry plan is simply another way to entice small employers to provide health care coverage. There are a variety of reasons why small businesses in particular are not an efficient vehicle for the delivery of health coverage to workers, including higher worker turnover rates and a greater share of marginal workers (part-time and seasonal) than is found among larger employers.[60]

  The Kerry policy strongly reinforces the existing third-party (employer and insurer) system that tightly controls the plans and benefits available to workers and their families. It also does little either to help create portability (so workers do not have to depend on their workplace or work status for health insurance) or to promote continuity of care. The funding for additional tax breaks for employers should be used to make individual health care tax credits more generous.

- **The various tax credits and subsidies for individuals are missing critical details.** While the Kerry proposal does target tax credits and subsidies to those who do not have employer-sponsored coverage, the details of their application are missing. For example, the

57. *Ibid.*

58. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 8. Urban Institute researchers have a more modest estimate of $177 billion over 10 years. See Leonard Burman and Jeffrey Rohaly, "Senator Kerry's Tax Proposals," Urban Institute and Tax Policy Center, July 23, 2004, p. 1.

59. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* Web exclusive, February 25, 2004, p. 1, at *content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1* (September 30, 2004).

60. For further discussion, see Stuart M. 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*.

Kerry plan would provide laid-off workers with a 75 percent tax credit "to assure [that] workers can keep their health insurance when they are between jobs."[61] Does this imply that workers receiving the tax credit would be able to use the credit only to maintain their existing (but costly) employer-sponsored coverage (i.e., COBRA coverage) or enrollment in the proposed Congressional Health Plan (CHP), or could they use the credit to obtain other coverage that would best reflect their own wants and needs? Would there be restrictions on the types of policies to which an individual could apply the credit, such as prohibiting the use of the credit for health savings accounts? The text of the Senator's description of the range of eligible consumer options is unclear.[62]

Answers to these and other questions are vital in assessing the proposal and its likely impact on personal freedom. How they are answered would reveal whether or not these health care tax credits and subsidies would help to transform the health care system to a consumer-based system or to one that remains employer-based but heavily regulated by the federal government.

A Better Approach. Senator Kerry's reliance on health care tax credits to expand coverage reflects an increasingly bipartisan approach to the problem of the uninsured. Health care tax credits are the key to expanding affordable coverage for millions of individuals and families. They are also the key to transforming the health insurance market from one that is dominated by employers, insurers, and government-run health care to a new system that is based on consumer choice and competition.

Much depends, however, on how these credits are structured and administered. Policymakers should build on the framework of individual tax credits. Targeting a refundable and advanceable tax credit to individuals and families in need would be a more effective use of federal dollars than using them to perpetuate distorted features of the status quo.

A new tax credit program could begin to move the health care system into a more consumer-oriented model in which individuals could own their own policies and maintain coverage regardless of their place of work or work status. Employers could continue to assist with their employees' health costs, but with greater flexibility. Instead of controlling the coverage, employers could simply provide a direct contribution to the plan of their employee's choice.

How Senator Kerry Would Use the FEHBP to Expand Coverage

Perhaps the most dramatic provision of Senator Kerry's health plan is his proposal to use the FEHBP as a vehicle to cover the uninsured. For administrative purposes, there would be a pool, the Congressional Health Plan, that is separate from the existing pool of federal employees and retirees.[63] This approach is intended to provide individuals with more affordable coverage, more choices, and lower premiums, as well as to give small businesses greater market clout and help reduce administrative costs.[64]

For large employers to participate in the CHP, the proposal requires that they maintain the current level of contribution and "not selectively segment

61. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 10.

62. For example, in the description of the Kerry health care tax credit for Americans between ages 55 and 64, the text reads: "John Kerry's plan will give this population access to a *variety of plan choices* under an affordable group plan [emphasis added]." Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 10. While this may or may not include association health plans or other emerging forms of group insurance, it appears to preclude a right to purchase individual health insurance. With the 50 percent business tax credit, the Kerry language discusses it in the context of the Congressional Health Plan but does not state that the CHP is the only permissible option for small businesses. However, in Professor Thorpe's analysis, the Kerry business tax credit is seemingly tied to enrollment in the new Congressional Health Plan, and the 75 percent tax credit for workers between jobs seems to be restricted either to COBRA coverage or to enrollment in the CHP. See Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," p. 2.

63. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," pp. 8–9.

their workforce into the CHP."[65] In other words, they must agree to send all, not just some, of their employees to the CHP. This is designed to curtail adverse selection in the program, the congregation of high risks in a few plans, and setting off high costs and instability in the market. Moreover, as with high-cost patients in private insurance, the Senator's premium rebate provision would apply to the high-cost enrollees in the FEHBP.

Analysis. The Federal Employees Health Benefits Program is the world's largest group health insurance program, covering more than 8 million federal workers, retirees, and their families. It has a clear record of success in controlling health care costs, providing a variety of choices in health plans and benefits, and achieving high levels of consumer satisfaction.[66]

This is why many health policy analysts, including those at The Heritage Foundation, have long promoted the FEHBP as a *model* for Medicare reform, particularly for the baby-boom generation.[67] It is also why many health policy analysts seeking a more efficient and effective state-based and consumer-driven market have suggested, with careful qualifications, the comparatively light regulatory regime that governs the FEHBP as a far superior alternative to the imposition of benefit mandates in state-based health insurance markets.

The FEHBP's success is based on personal choice and market competition. It is not based on the generosity of the employer's contribution to coverage or the richness of its benefit package.[68] In any case, there is no one FEHBP benefits package. The program includes a variety of benefits packages that reflect different offerings by different plans (including health savings accounts) with different levels of premiums, deductibles, co-payments, and coinsurance. This is a crucial point overlooked by congressional spokesmen who routinely tell the public that they favor giving ordinary Americans the "same" benefits that Members of Congress enjoy.

There is a world of difference, however, between proposing the FEHBP as a *model* for health care reform and using the program itself as the primary vehicle for enrolling the uninsured. Indeed, certain prescriptions for the Congressional Health Plan outlined by Senator Kerry are the polar opposite of current practices in the FEHBP, meaning that the dynamics of CHP would be very different from today's FEHBP. These crucial differences would result in profoundly different program dynamics, negatively affecting the FEHBP itself.

First, the FEHBP is, broadly speaking, a "defined contribution" program in which the government as employer contributes up to 75 percent of the cost of a premium for a plan in the program. (Federal employees cannot take the government's contribution and buy a plan outside the program.) The government contribution is annually calculated on the basis of the weighted average of premiums that prevail in the FEHBP market and capped each year at a specific dollar amount. If any given plan is more expensive than the capped amount, the federal worker pays the full difference between the government contribution and the premium. With frugal plan purchase, therefore, there is also a definite limit to the taxpayers' exposure.

64. *Ibid.*, p. 9. It is worth noting that, since the Office of Personnel Management has plenary authority to negotiate rates and benefits within the FEHBP, any participating businesses, large or small, would be the passive beneficiaries of OPM's exercise of "market clout."

65. *Ibid.,* p. 10.

66. On these points, consult Walton J. Francis, "The FEHBP As a Model for Medicare Reform: Separating Fact from Fiction," Heritage Foundation *Backgrounder* No. 1674, August 7, 2003, at *www.heritage.org/research/healthcare/bg1674.cfm*.

67. See Walton J. Francis, "Using the Federal Employees' Model: Nine Tests for Rational Medicare Reform," Heritage Foundation *Backgrounder* No. 1675, August 7, 2003, at *www.heritage.org/research/healthcare/bg1675.cfm*. See also Robert E. Moffit, "What the GAO Says About the Best Model for Medicare Reform," Heritage Foundation *Backgrounder* No. 1625, February 21, 2003, at *www.heritage.org/research/healthcare/bg1625.cfm*.

68. Historically, private corporate benefit packages have been more generous than those traditionally available in the Federal Employees Health Benefits Program.

By contrast, in the proposed Congressional Health Plan, at whatever level employers or individuals contribute, the various tax breaks and subsidies to offset the premium costs are simply raw percentages of the cost of plan premiums, with no fixed dollar cap. For individuals, under the Kerry plan, health insurance premiums could not exceed 6 percent of personal income. Presumably, even if a person were to choose the most expensive plan available through the FEHBP, there would be no limit on the credit or subsidy but the raw percentage of the premium. This would significantly increase the taxpayers' exposure, while the program's cost would increase.

Second, in the FEHBP today, competing health plans, not the taxpayers, assume the risk. The federal government is not self-insured. Because the health plans assume the risks, those that do not manage risk well, including the serious risks of high cost enrollees, end up losing market share or leaving the program.

In the proposed Congressional Health Plan, as in the FEHBP itself, Senator Kerry's proposed "premium rebate" for high-cost enrollees would apply, meaning that taxpayers, as noted, would assume the full cost of high risks, starting at the $30,000 threshold in 2006. This is a radical break from current FEHBP practice. According to the official description of the Kerry plan, it

> will provide uninsured individuals protection from unaffordable premiums by providing assistance with costs above six percent of their income. In addition, a 'premium rebate pool' for certain high cost health cases will help reduce health care costs for all Americans. It will help assure that premiums in the Congressional Health Plan are affordable.[69]

This expansion of taxpayers' exposure, so radically unlike today's FEHBP, will guarantee soaring costs in the program.

The Kerry plan would also change the governance of the program because the rules governing the Congressional Health Plan presumably are to be the same as those in the traditional FEHBP. The rising costs and differences in financing and cost sharing would surely invite a much heavier level of regulation by officials at the Office of Personnel Management (OPM). That heavier regulation would further transform the FEHBP into a program very different from the one that exists today.

Limitations of the FEHBP. The FEHBP is a unique employment-based health insurance plan. It is designed as employment-based coverage for federal employees and retirees, a significantly older population that is different in many respects from the general population, let alone the uninsured population. The rates and benefits that prevail in the FEHBP reflect that simple fact.

Federal workers and retirees comprise a unique health insurance pool. It is an older cohort of the American population. The average age of the federal workforce is roughly 47 years,[70] and FEHBP enrollment is also open to federal retirees, who comprise roughly 40 percent of total enrollment. Thus, the average age of the FEHBP enrollee is 61.[71]

As a workforce, the federal employees are largely middle-class with an overall average annual salary of $55,715, while federal workers in the Washington, D.C., metropolitan area have an average salary of $71,139.[72] Not surprisingly, the economic and demographic profile of this community is reflected in the FEHBP's rates and benefits, and 85 percent of federal employees choose to enroll.[73] For calendar year 2005, based on OPM's 2004 negotiations with private health plans, the

69. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 9.

70. Kay Coles James, Director, U.S. Office of Personnel Management, remarks before the American Association of Health Plans National Policy Forum, February 25, 2004, p. 4.

71. Kay Coles James, Director, U.S. Office of Personnel Management, address to the Blue Cross, Blue Shield Employees program, June 2, 2003, p. 6.

72. U.S. Office of Personnel Management, *Federal Civilian Workforce Statistics: Pay Structure of the Federal Civil Service as of March 2002*, December 2003, p. 2, at *www.opm.gov/feddata/02paystru.pdf* (September 30, 2004).

average single premium is $4,733; the average family premium is $10, 756.[74]

The Congressional Health Plan will thus likely experience certain difficult problems. For example:

- **FEHBP benefits are likely to be very expensive for younger uninsured workers.** According to the official description of the Kerry plan, "John Kerry believes that all Americans should have access to the same affordable coverage policies that Members of Congress get today." [75] A key detail is whether the benefit packages in the CHP must be exactly the same as the benefit packages in the FEHBP.

  But if the benefit levels in the Congressional Health Plan are to be the same as those in the FEHBP, benefits packages are going to be expensive for a much younger, lower-income, working, uninsured population that is disproportionately concentrated in small businesses. In fact, more than one-third of all uninsured people have incomes below the federal poverty level.[76] If potential enrollees could purchase cheaper health insurance elsewhere, getting better value for the money, there would be no obvious reason for them to enroll in the CHP.

- **Unlike the traditional FEHBP, the new CHP would likely suffer from serious adverse selection.** Even though the FEHBP is a pluralistic system of competing health plans with a wide variety of choice, it does not suffer from significant adverse selection. Instead, it is a remarkably stable health insurance market. A key reason for this is the generosity of the government's defined contribution—up to 75 percent of the cost of the health plan—which encourages younger federal employees to select more generous coverage and thus encourages a more even age distribution in the program.[77]

  The CHP is unlikely to replicate the FEHBP performance in mitigating adverse selection. Much depends on whether the Senator's proposed business tax credits or subsidies could be used more effectively to purchase health insurance packages that are more affordable than those that prevail in the FEHBP. A 50 percent small business tax credit, combined with the specified 50 percent premium payment, may still not be attractive to firms willing to accept government conditions for enrolling all of their employees in the CHP. Many younger and healthier uninsured workers are in small firms, and FEHBP-level plans may be either unaffordable or unattractive for them.[78]

  Other details also matter. The FEHBP's underwriting rules presumably would be the same in the CHP. The FEHBP has a crude form of "community rating" in which older and sicker persons pay the same rates as younger and healthier persons. For the young and healthy, these underwriting rules may make the benefits packages less attractive or affordable, and the tax credits and subsidies may still not be enough to induce enrollment in the CHP.[79] Once again, there would be no reason for them to enroll in the CHP if they could purchase less expensive health care coverage elsewhere.

  However, for persons with health care costs that are high compared to their income—

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73. U.S. Office of Personnel Management, Federal Employees Health Benefits Program Fact Sheet, September 14, 2004.
74. Personal communication with Walton Francis, editor, *Checkbook's Guide to Health Plans for Federal Employees*, October 6, 2004.
75. Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 8.
76. Stan Dorn, 'Towards Incremental Progress: Key Facts About the Uninsured," Economic and Social Research Institute *ESRI Fact Sheet*, September 2004.
77. See Curtis S. Florence and Kenneth E. Thorpe, "How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?" *Health Affairs*, Vol. 22, No. 2 (March/April 2003), pp. 211–218, at *content.healthaffairs.org/cgi/reprint/22/2/211* (September 30, 2004, subscription required).
78. The Kerry plan references the Congressional Health Plan in connection with the 50 percent business tax credit, but the text does not indicate that the CHP is the exclusive option. See Kerry–Edwards 2004, "John Kerry's Plan to Make Health Care Affordable to Every American," p. 9.

regardless of their age or job status—enrollment in the CHP, with enormous back-end taxpayer subsidies for their premiums and high-end costs, could prove irresistible. Moreover, they would have a powerful incentive to enroll in one of the richer and more expensive plans that participate in the program.

Assuming, once again, that the rules for the new CHP would be the same as those for the FEHBP, there could be no pre-existing condition exclusions, and there would be no risk-adjustment mechanism. By attracting older and sicker enrollees over time, the premiums in the Congressional Health Plan would likely discourage younger and healthier enrollees, who make up the bulk of the uninsured population.

It is also unclear whether all of the health plans that provide coverage nationally to federal workers and retirees would also be required to provide coverage to the uninsured nationally under the Congressional Health Plan. Presumably, they would, and the rules would be the same. Because these are very different populations, with very different experiences, this could be a crucial question for these national plans, determining their participation and thus the success of the CHP.

- **The Congressional Health Plan would likely become an engine of federal control rather than a force to promote free-market competition.** The FEHBP's success is not based on efficient administration by the career civil servants at the Office of Personnel Management. It is based on its free-market principles of consumer choice and competition, and a historic hesitation on the part of government officials to micromanage the program.

  Given the key elements of the Kerry proposal—particularly insistence on the taxpayers' assumption of risks and high-end costs and the potential for adverse selection—a Congressional Health Plan created within the FEHBP would likely devolve into an overregulated, government-controlled system of limited competition, with consumer choice restricted to a government-standardized benefits package offered by a few, select plans commissioned by the federal government. Since the two pools could not coexist in the same program with radically different rules—one set for federal workers and another for non-federal enrollees—it is likely that the traditional FEHBP would be altered beyond recognition.

A Better Approach. The FEHBP is a successful program because of its wide range of choice and competition, but it is not perfect.

Rather than trying to use the FEHBP as a primary vehicle to cover the uninsured, which involves a variety of difficult administrative problems, policymakers should use it as a *model.* They should build on the best features of the FEHBP—including broad consumer choice, market competition, and a light regulatory regime—and encourage the states to create statewide pooling arrangements based on these principles. In so doing, the states could also experiment with new insurance rules to expand coverage and new risk-adjustment mechanisms or reinsurance arrangements.

Unlike the FEHBP, states should also allow premium variations based on age and health risk, as well as establish a private-sector–administered reinsurance pool to mitigate potential adverse selection problems. Moreover, a refundable tax credit approach would be more productive with insurance products that are already available within the existing individual market.[80]

Such an approach could replicate the best features of the FEHBP while allowing variations in

79. Even in the FEHBP, where federal employees get a generous government contribution of up to 75 percent of their premium costs, about 8 percent of federal workers do not enroll because they cannot afford the 25 percent of the premium costs and the cost sharing. Personal communication with Walton Francis, October 6, 2004.

80. See estimates based on analysis of 62,000 plans conducted by eHealthInsurance, one of the nation's largest Internet brokers of health insurance. Derek Hunter, "New Data on Health Insurance, the Working Poor, and the Benefits of Health Care Tax Changes," Heritage Foundation *WebMemo* No. 492, April 28, 2004, at *www.heritage.org/research/healthcare/wm492.cfm*.

health care financing and delivery peculiar to the conditions that prevail in the states.

Financing the Kerry Health Proposals

There are a variety of cost estimates on the Kerry health plan. In any case, as Jeff Lemieux, executive director of Centrists.Org and former Congressional Budget Office (CBO) analyst, has observed, "Taken as a whole, the Kerry plan is very expensive."[81]

Professor Ken Thorpe of Emory University, a nationally prominent health policy analyst who served in the Clinton Administration, says the Kerry plan would cost an estimated $653 billion over 10 years.[82] For this proposed expenditure, he estimates that the Kerry plan would secure a net increase of insurance coverage for about 27 million Americans.[83]

However, more recent estimates conducted by other independent health analysts conclude that the Kerry plan would impose a much higher cost. According to a report prepared by Joseph Antos and his colleagues for the American Enterprise Institute, the Kerry plan would cost $1.5 trillion over 10 years.[84] The Lewin Group, a leading econometric firm specializing in health care policy, concluded that the Kerry plan would cost $1.25 trillion over 10 years.[85] These two analyses roughly substantiate an earlier projection by analysts at the National Center for Policy Analysis, who estimated that the Kerry plan would cost in excess of $1 trillion over 10 years.[86]

Senator Kerry proposes to pay for his health care initiatives through new tax initiatives, particularly by rolling back President Bush's tax cuts for upper-income families with an annual income of more than $200,000. This would include raising the two top tax rates from 33 percent to 35 percent and from 36 percent to 39.6 percent, respectively. The Kerry plan would also reverse the Bush tax cuts on capital gains and dividends for upper-income families and preserve, rather than end, the estate tax. The Senator would also repeal additional Medicare payments to private health plans in Medicare.[87]

The Heritage Foundation's Center for Data Analysis estimates that the proposed Kerry personal tax rate changes for these upper-income Americans alone would generate total revenues of only $174.3 billion over the period 2005–2014.[88] Moreover, the Senator's total tax and spending package would increase, not decrease, the budget deficit.[89] Based on the preponderance of empirical analyses, the proposed tax increases are unlikely to cover the costs of the Kerry plan.

Analysis. Assumptions are key in making cost projections. Different assumptions yield very different estimates.

For example, Professor Thorpe included assumptions concerning Senator Kerry's promotion of dis-

81. Lemieux, "Senator Kerry's Health Proposal," p. 2.
82. Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," p. 1.
83. *Ibid.*, p. 5.
84. Antos *et al.*, "Analyzing the Kerry and Bush Health Proposals," p. 1.
85. Sheils and Haught, "Bush and Kerry Health Care Proposals," p. 5.
86. Goodman and Herrick, "The Case Against John Kerry's Health Plan."
87. This refers to the Medicare "stabilization fund" created under the Medicare Modernization Act of 2003 to encourage health plan participation. Repeal would yield an estimated $14.4 billion over 10 years. See Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," p. 8.
88. Estimates are based on a "static" analysis. William W. Beach, Ralph A. Rector, Rea S. Hederman, Alfredo Goyburu, and Tim Kane, "The Candidates' Tax Plans: Comparing the Economic and Fiscal Effects of President George W. Bush's and Senator John F. Kerry's Tax Proposals," Heritage Foundation *Center for Data Analysis Report* No. CDA04–09, September 20, 2004, at *www.heritage.org/Research/Taxes/cda04-09.cfm*.
89. Brian M. Riedl, "Would Senator Kerry's Budget Really Reduce the Deficit?" Heritage Foundation *Backgrounder* No. 1797, September 21, 2004, at *www.heritage.org/reseachbudget/bg1797.cfm*.

ease management techniques and the broader dissemination of information technology. He assumed that disease management would save almost $116 billion over 10 years—a substantial reduction in health care costs.[90] The Lewin Group estimated that the Kerry plan's disease management initiatives would save $22.3 billion over 10 years.[91]

There is a long and undistinguished record of analysts making assumptions about the future costs of health care programs, particularly those with a large government component. If anything, there is a tendency to underestimate the true costs of health programs, particularly government health programs. This caution applies with special force to the Kerry health proposals because the incentives are geared toward increasing rather than containing health care spending.

Conclusion

Senator Kerry has proposed a major set of health policy proposals that, if enacted, would increase health care federal spending well in excess of $1 trillion during the first 10 years of their implementation.

The Senator's plan amounts to a major expansion of government programs—including Medicaid, the State Children's Health Insurance Program, and the Federal Employees Health Benefits Program—as vehicles to secure insurance coverage for the uninsured. Meanwhile, the Senator has also proposed that the federal government assume the bulk of the most expensive claims incurred in private health insurance, thus shifting the heaviest health care costs to the federal taxpayer. This arrangement would be accompanied by a much higher level of federal regulation over employment-based health care than exists today.

In fact, the Kerry plan is a wide array of distinct proposals that touch everything from disease management and information technology to medical malpractice and prescription drug coverage. Perhaps the most dramatic provision of the Senator's plan is his proposal to open the FEHBP to the uninsured, putting employers and employees in a special pool called the Congressional Health Plan. Because of the Senator's proposed changes, however, the FEHBP would not work as it does today.

Based on independent estimates, it appears that the Senator's proposals would significantly increase federal health care spending while substantially reducing the number of Americans who are without insurance coverage. At the same time, he would refrain from undertaking any substantial reform of either private health insurance markets or government health care programs, including Medicaid. While existing third-party payment arrangements would be retained and expanded, individuals and families would still be unable to own and control their health insurance policies. In that respect, the Senator's proposals fall far short of comprehensive reform.

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90. Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," p. 4, Table 1.

91. Lewin Group, "Bush and Kerry Health Care Proposals," p. 6.