Policy Analysis

Cato Institute Policy Analysis No. 184: Health Care Reform: The Good, the Bad, and the Ugly

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Executive Summary

While Congress has actually taken little action on health care reform, there has been no shortage of discussion on Capitol Hill. This year alone Congress has considered more than 100 bills on health care that range from two pages to more than 200 pages. In addition, the Bush administration released a 94-page outline of its health care reform program. President-elect Bill Clinton also has a health care plan. And nearly every think tank with a word processor has contributed a proposal as well.

Those proposals run the gamut--from good to bad to ugly. The ideas receiving the most discussion in the media are those that would increase the involvement of government in health care. That first group of proposals is focused on methods of financing expanded access to health insurance. They generally take one of two approaches: (1) a universal, single-payer, government-operated, tax-funded system or (2) a "play or pay" system, built around a mandate on employers. The second set of proposals attempts to accomplish the same goals without spending more money. Those proposals often focus on regulatory manipulation of the insurance industry. Most other proposals would change the behavior of health care consumers, generally through some form of tax incentive.

Single-Payer Systems

One of the most dangerous health care reform proposals currently being considered is the call for a single-payer, government-operated, tax-funded system--the type of system, generally referred to as national health care, currently operated in Canada, Europe, Australia, New Zealand, and elsewhere.

The legislation generally cited as the classic example of a single-payer health care plan is sponsored by Rep. Marty Russo (D-Ill.) and Sen. Paul Wellstone (D-Minn.). That legislation specifically establishes health care as an entitlement for every American citizen. Every person would be issued a national health card. Payment for all medically necessary services would be provided through a government- operated program, which would be funded by taxes. Benefits would include a plethora of medical services, including long-term care. The federal government would establish a national budget and individual state budgets for operating expenses, capital outlays, and medical training. Individual hospitals would operate on preset yearly budgets. Physicians would be reimbursed on the basis of fees determined by the government. The national plan would replace all current government programs, including Medicare and Medicaid.[1]

A single-payer national health care system would come at enormous cost to American taxpayers. For example, Russo-Wellstone would require employers and the self-employed to pay a tax equal to 7.5 percent of wages. The top individual tax rate would rise from 31 to 38 percent. Corporate income taxes would increase from 34 to 38 percent. Social Security benefits would be taxed at 85 percent rather than the current 50 percent. And the elderly would be assessed a $55 per month fee for long-term care.[2] Even those levies may not be enough to pay for national health

care. Some economists put the cost as high as $339 billion per year in additional taxes.[3]

For all that tax money, we would buy surprisingly little health care. The one common characteristic of all national health care systems is a shortage of services. For example, in Great Britain, a country with a population of only 55 million, more than 800,000 patients are waiting for surgery.[4] In New Zealand, a country with a population of just 3 million, the surgery waiting list now exceeds 50,000.[5] In Sweden the wait for heart x-rays is more than 11 months. Heart surgery can take an additional 8 months.[6] In Canada the wait for hip replacement surgery is nearly 10 months; for a mammogram, 2.5 months; for a pap smear, 5 months.[7] Surgeons in Canada report that, for heart patients, the danger of dying on the waiting list now exceeds the danger of dying on the operating table.(8] According to Alice Baumgart, president of the Canadian Nurses Association, emergency rooms are so overcrowded that patients awaiting treatment frequently line the corridors.[9] Table 1 gives the average wait for various types of physicians' services in five Canadian provinces.

Table 1
Canadian Survey of Physicians:
Average Weeks Waited by Patients (by Specialty)

	B.C.	N.B.	Nfl.	Man.	N.S.
Plastic surgery	13.2	36.2	37.0	11.0	26.3
Gynecology	8.4	10.9	5.3	9.0	9.6
Ophthalmology	11.6	5.2	2.9	12.8	10.7
Otolaryngology	12.2	7.2	n/a	7.0	14.7
General surgery	4.0	2.5	8.0	8.2	4.0
Neurosurgery	4.2	8.3	9.0	10.5	5.8
Orthopedic	15.8	14.6	18.5	20.6	19.7
Cardiology	14.0	10.0	42.6	14.7	26.0
Urology	8.3	13.2	5.0	6.7	7.1
Internal medicine	5.5	4.5	2.2	3.3	2.0

Source: Fraser Institute, cited in Reason, March 1992.

Sometimes the rationing of care is even more explicit: care is denied the elderly or patients whose prognosis is poor. In Britain kidney dialysis is generally denied patients over the age of 55. At least 1,500 Britons die each year because of lack of dialysis.[10]

Countries with national health care systems also lag far behind the United States in the availability of modern medical technology. It is well documented that in Canada, high-technology medicine is so rare as to be virtually unavailable.[11] That comparison holds for other countries as well. Advanced medical technology is far more available in the United States than in any other nation.[12] In addition to being biased against new medical technologies, national health care systems generally discriminate against nontraditional practitioners, such as naturopaths and chiropractors.[13] Figure 1 shows the availability of some high-tech medical technologies in the United States, Canada, and Germany.

Furthermore, national health care systems do not control the rising cost of health care. Proponents of national health care make much of reported differences in the proportion of gross domestic product spent on health care by Canada and the United States. It is true that Canada spends only about 9 percent of its GDP on health care, while U.S. costs have skyrocketed to more than 14 percent of GDP.[14] However, such comparisons are seriously misleading.

Figure 1

Availability of Medical Technologies
[Graph omitted.]

Sources: Rublee, "Medical Technology in Canada, Germany and the United States, Health Affairs, Fall 1989; John Goodman, "National Health Insurance and Rural Health care, "American Farm Bureau Research Foundation; and Eli Lilly Company.

Between 1967 and 1987 the Canadian GDP grew at nearly twice the rate of the U.S. GDP. Therefore, any comparison of health spending should be adjusted to compensate for the different rates of economic growth. Additional adjustments should be made for such factors as population growth; general inflation; currency exchange rates; the larger U.S. elderly population (the elderly require more, more expensive, health care); higher U.S. rates of violent crime, poverty, AIDS, and teen pregnancy; and greater U.S. investment in research and development. When all such factors are taken into account, Canadian health spending is virtually identical to that of the United States and has actually been rising faster over the last several years.[15] Indeed, Canadian public policy experts warn that health care costs are rising so rapidly that "they are crowding out every other public spending priority--social services, the environment, education. All are being shortchanged to feed an inefficiently organized health care system."[16]

Play or Pay

The second most commonly discussed proposals for health care reform are called "play or pay." Under a play-or-pay plan, employers would be required either to provide health insurance for all workers or to pay a tax that would fund health insurance for those who remain uninsured.

However, attempts to mandate that business shoulder the burden of health care costs run into the wall of simple economics. The amount of compensation each worker receives is directly related to that worker's productivity. Mandating an increase in compensation by requiring the employer to provide health insurance does nothing to increase productivity. Thus, one of two things happens: either consumers must pay higher prices for products or, more likely in a competitive economy, employers are forced to reduce their payroll costs to offset the new and increased costs of health benefits. Payroll reductions may take several forms. One is a reduction in cash compensation, which in practice is unlikely. More probable is a reduction in the number of employees: either workers would be laid off, or the hiring of new employees would be postponed. In either case, unemployment would increase, especially among low-skilled workers for whom mandated health benefits would constitute a relatively large increase in compensation.[17]

The National Federation of Independent Business, which represents more than 500,000 small businesses in all 50 states, surveyed its members and found that 23 percent would be forced to lay off employees if a play-or-pay system imposed an additional cost of only $100 per employee per month. Nearly 22 percent indicated that they might be forced out of business altogether.[18] Overall, economists have placed the estimate of jobs lost under play or pay at between 630,000 and 3.5 million.[19]

There is a particular unfairness to play or pay. Although most individuals without health insurance are the working poor, studies show that 25 percent of the uninsured have incomes of more than 300 percent of the poverty level.[20] Those people are frequently young, healthy individuals who, preferring to spend their discretionary income elsewhere, have chosen not to purchase health insurance. Under a play-or-pay system, low-skilled poor people would lose their jobs to provide those relatively affluent individuals with government-funded health insurance.

Like single-payer plans, a play-or-pay program would have enormous costs for American taxpayers and businesses. The Urban Institute, in a study commissioned by the U.S. Department of Labor, estimated that play or pay would cost taxpayers at least $36 billion per year in higher taxes and would cost businesses an additional $30 billion in higher health care costs.[21] Other economists warn that play or pay would increase the budget deficit by $46.5 billion and would reduce the U.S. gross national product by $27 billion.[22]

Perhaps most important, play-or-pay systems are sure to degenerate into a national health care system, with all its attendant problems. Again, the reason is simple economics. The average business currently pays nearly $4,500 per employee for health care benefits.[23] That is 22.5 percent of the salary of an employee making $20,000. If the payroll tax were 7 percent, as envisioned under current proposals,[24] the obvious choice for the employer would be to pay the

tax and turn the employee's insurance over to the government.[25] That scenario is even more likely for big businesses, such as the automobile industry, that provide very extensive, and expensive, health benefits.[26] One reason certain big businesses, such as Chrysler and AT&T, are so supportive of such a plan is that they would be only too happy to foist their health care costs onto others. Figure 2 shows the gap between "playing" and "paying."

Figure 2
The "Play or Pay" Gap
(Graph Omitted)

As the government assumed responsibility for providing health care to more and more workers, the play-or-pay system would transform itself into a Canadian-style national healthcare system. Indeed, Katherine Swartz of the Urban Institute has said, "The strongest argument for enacting a 'play or pay' proposal is that it will enable the country to move from our current patchwork quilt structure to a single, national system with time for creating and implementing an efficiently run public program."[27]

Insurance Regulation

The third commonly discussed reform of our health care system is changing insurance laws. The goal is to reduce insurance costs or make insurance more available to more people. The most common target for those reforms is the small-group market. According to the Employee Benefits Research Institute, nearly 85 percent of Americans without health insurance are either employed or are the dependents of employees. Nearly half of the uninsured workers are employed by companies with 25 or fewer employees (see Figure 3).[28]

Figure 3 **Working Uninsured by Size of Employer**	
Employees	Percentage
1-24	47.6
25-29	14.6
100-499	12.2
500+	25.6

Source: Employee Benefits Research Institute

Some of the proposed insurance market reforms, such as eliminating mandated benefits, are sensible.[29] However, there are increasing efforts to manipulate insurance laws to require insurers to provide coverage for groups or individuals that they would not normally cover. The following are among the most commonly proposed reforms.[30]

* Renewability: Insurers would be prohibited from canceling policies for groups or individuals within a group because of deteriorating health of the group or one of its members.

* Continuity: Insurers would be prohibited from imposing new restrictions on a previously insured individual when he or she changes jobs. Some variations would go further by making an employee's insurance package "portable," enabling it to be carried from job to job.

* Premium Limits: Limits would be imposed on how much an insurer could vary rates between similar groups. Limits would also be imposed on how much an insurer could raise rates from year to year.

* Guaranteed Issue: Insurers would be prohibited from denying coverage to any small group or excluding any employee within a group.

* Community Rating: All insured individuals within a designated category would pay the same rate regardless of individual risk.

Most of those insurance reforms have the worthy intent of expanding access to insurance to small employers that have been unable to purchase insurance under current practices. But the reforms may have unintended consequences that will increase the cost of insurance and actually leave more people without insurance.[31]

Insurance is a business of risk allocation in which the insurer receives payment in exchange for agreeing to cover the expense of the event insured against. The cost and scope of coverage are determined by morbidity-mortality statistical analysis. To the degree that insurers are prevented from basing their contracts on actuarial values, other policyholders will be forced to absorb the additional costs. Indeed, studies estimate that, while employers with high-risk employees would certainly notice improved access to coverage under proposed insurance reforms, premiums could increase overall by as much as 20 to 25 percent.[32] In some cases, premiums could rise by as much as 35 percent.[33]

The net result would be to force many small businesses to drop their present insurance coverage. Some currently uninsured workers would move into the insurance market, but others who now have insurance would move out. Thus, insurance reforms would defeat their own purpose.

It should also be noted that most insurance reform proposals would benefit large insurers, whose cash reserves and larger profit margin give them more flexibility to meet the new demands, at the expense of smaller companies. For those large insurers, the specter of national health care is of more concern than are the problems of insurance reform. If the small-group market must be sacrificed to prevent national health care, so be it. That reasoning may explain the support accorded many reform proposals by the Health Insurance Association of America (HIAA) and Blue Cross-Blue Shield.

As insurance expert Arthur Ferrara has noted:

> Equitable distribution of this burden was not a high priority of [HIAA]. The larger companies exercise a commanding position on HIAA committees and its Board. Concerned over the specter of national health insurance, they convinced the Board to adopt a poorly conceived plan. . . . The cost of the proposal will not affect those large companies and their policyholders. They are not significantly involved in the small employer group market, and are apparently not involved in the cost of the solution proposed.[34]

Managed Competition

The latest buzzword in health care reform is "managed competition." Managed competition proposals are being presented as a compromise that would preserve many free-market aspects of health care but make the market more accountable to government control. The concept is generally considered the brain child of the Jackson Hole Group, an ad hoc coalition of health care executives and academic experts led by Dr. Paul Ellwood.[35] In Congress it is supported by the Conservative Democratic Forum.[36] It has also received consistent and enthusiastic support from the New York Times.[37]

As envisioned under the most common managed-competition proposals, there would be established a national system of Health Insurance Purchasing Cooperatives (HIPCs), which would act as collective purchasing agents on behalf of employers and individuals.[38] All Americans would be enrolled in an HIPC, either through their employer or individually.[39] The HIPC would negotiate with Accountable Health Partnerships (AHPs) for a benefits package for its members, much the way German sickness funds do.[40] AHPs would be private insurance organizations approved by the government on the basis of their ability to (1) provide a full array of designated health benefits, (2) "produce a high level of patient- oriented results," and (3) control costs.[41] The government would establish a Uniform Effective Health Benefits package as a minimum standard benefits requirement, which would replace current state-mandated benefits. AHPs would be required to charge all members of the HIPC the same premium regardless of risk (community rating) and to guarantee coverage to all HIPC members.[42]

Employers would be required to provide coverage for all full-time employees. Employers would have to pay at least half the cost of coverage, but to discourage excessive benefits, the employer's tax deduction would be limited to the amount of the lowest cost plan offered by an AHP. Unlike the situation under play or pay, employers would not have the option of paying rather than providing coverage. However, employers would be required to pay a payroll tax for noncovered part-time workers. Unemployed people with incomes and the self-employed would also have to pay a tax.

Those taxes would be collected by the federal government, then returned to the states on an "equalized" basis that took into account the number of uninsured workers in each state. States with high rates of uninsured would receive the most funding.[43] States would use that federal money, plus current money from uncompensated-care and indigent-care funds, to subsidize insurance purchased by those not covered through an employer and unable to pay the full insurance cost themselves.[44] Public programs, such as Medicare and Medicaid, would have the option of purchasing care through an HIPC.[45]

The program would be overseen by a new, independent federal agency, the National Health Board, that would be removed from day-to-day oversight by Congress or the executive branch, as is the Securities and Exchange Commission. The program also envisions three additional agencies established by legislation but controlled by a combination of employers, consumer groups, health care providers, and insurers. Those would be the Health Standards Board, to review medical efficacy and assess benefits; the Health Insurance Standards Board, to oversee insurance organization and market issues; and the Outcomes Management Standards Board, to oversee a new program for providing increased information to health care consumers.[46] Figure 4 is an organizational chart of the managed-competition system.

Figure 4
Managed Competition
Source: Conservative Democratic Forum
(Chart Omitted)

As proposed, managed competition appears to offer a great deal of management and very little competition. Often discussed as a compromise between various health care reform proposals, managed competition incorporates many of the worst elements of other proposals.

First, as was mentioned earlier, the mandate that employers provide health benefits for all full-time employees will cost jobs. Even the Jackson Hole Group admits that "employer mandates are a form of employment tax."[47] They claim, however, that explicit taxes would be "fairer" than the current system of allocating costs.

At the same time, the revenues generated from a combination of payroll taxes on part-time workers, taxes on the self-employed and unemployed, and savings from uncompensated care are likely to fall well short of the cost of providing extended Medicaid benefits and subsidies for the uninsured. Those costs are estimated to be least $29.7 billion per year.[48] Further, the proposal to "equalize" the return of tax revenue will penalize states with policies that encourage economic growth and benefit those states whose high taxes and business regulations cause slower economic growth.

Second, the proposal creates not just one but four new government bureaucracies. While no real estimate of the cost of those agencies has been made, it can be assumed to be substantial. Even more worrisome is the proposal to exempt the agencies from legislative or executive oversight. The history of "independent" agencies, such as the Food and Drug Administration, the Federal Trade Commission, the Federal Communications Commission, and the SEC, has been one of continued expansion, resistance to marketplace innovation, and frequent episodes of corruption and abuse.

Third, the call for uniform effective health benefits simply moves the problems of mandated insurance benefits from the state to the federal level. The inclusion of a given benefits package in the mandate is much more likely to be based on the relative lobbying strength of various provider groups than on a rational view of medical necessity. Whatever benefits are mandated will increase the cost of insurance, and consumers will be deprived of the ability to make individual choices about the types of benefits they wish to purchase. And fourth, as was mentioned earlier, requirements for guaranteed issue and community rating will increase the cost of insurance.

Finally, the proposal is vague about how it will control overall health costs. The Conservative Democratic Forum claims that cost controls will result from (1) capping the tax deductibility for employers who provide insurance in excess of the lowest cost plan, (2) increased government spending for preventive health care programs, (3) tort reform, (4) paperwork reduction, and (5) holding providers and insurers "accountable for costs and medical outcomes."[49] However, the ability of the first four of those cost-control measures to hold down costs is unproven, and the fifth sounds suspiciously like price controls.

Tax Incentives

Current federal and state tax laws exclude from taxable wages the cost of health insurance provided by an employer. Therefore, the vast majority of Americans, who receive health insurance through their employers, do not pay federal, state, or Social Security taxes on the value of their policies. Moreover, the employer can deduct the full premium cost as a business expense. Employers do not even pay Social Security payroll taxes on health care benefits. In short, the entire cost of employer-provided insurance is paid with before-tax dollars.

However, those Americans not fortunate enough to receive employer-provided health insurance face entirely different tax laws. For example, self-employed individuals and their families may deduct only 25 percent of the cost of health insurance. In addition, self-employed individuals must pay Social Security taxes on money used to purchase health insurance.

Part-time workers, students, the unemployed, and everyone else not receiving employer-provided health insurance--including most employees of small businesses[50]--are unable to deduct any of the cost of health insurance. (Individuals may only deduct out-of-pocket medical expenses if they itemize deductions and the expenses exceed 7.5 percent of adjusted gross income. Fewer than 5 percent of taxpayers are eligible for that deduction.)[51]

The difference in tax treatment creates a disparity that effectively doubles the cost of health insurance for people who must purchase their own. For example, the family of a self-employed person who earns $35,000 a year and pays federal and state taxes with only a 25 percent deduction and Social Security taxes must earn $7,075 to buy a $4,000 health insurance policy. A person who works for a small business that offers no health insurance would have to earn $8,214 to pay for a $4,000 policy. Table 2 gives the effective cost of acquiring a $4,000 policy for each of the employment groups.

Table 2
Effective Cost of a $4,000 Health Insurance Policy for Family with Adjusted Gross Income of $35,000

	100% Tax-Free Covered Policy(a)	25% Tax Deductible Self-Employed Policy(b)	100% Taxed Individually Purchased Policy(c)
Additional earnings needed to purchase a $4,000 health insurance policy	3,716d	7,07	8,214
Less 28% marginal federal tax rate	0	-1,701(e)	-2,300
Less 8% marginal state income tax	0	-486(e)	-657
Less payroll taxes(f)	+284	-888(g)	-1,257

aFunds used by an employer to purchase health insurance are exempt from federal, state, and local income taxes as well as Social Security taxes.

bSelf-employed workers can deduct 25 percent of their health insurance costs from federal and state taxable income.

cEmployees who purchase health insurance on their own must pay for their health insurance with after-tax dollars.

dThough paid for by the employer, the policy is part of an employee's total compensation package. If employers had to pay federal, state, and payroll taxes on the value of health insurance purchased, workers' take-home pay would be reduced by a corresponding amount.

eThe self-employed may deduct 25 percent of the cost of their health insurance premiums from their earnings for

calculating federal and state taxes.

fEconomists generally agree that both the employee and employer shares of payroll taxes represent a tax on a worker's wages.

gWhile income needed to purchase health insurance by the self-employed is not exempt from taxes, the self-employed were able to deduct from their taxable income one-half of their Social Security taxes, or 7.65 percent, in 1991.

Figure 5
Health Insurance by Tax Status

Status	Insured (%)	Uninsured (%)
100% Tax-Free Employer Provided Coverage	97.2	2.8
25% Tax-Deduction Self-Employed Coverage	71.4	26.6
0% Tax-Deduction for Individuals Purchasing Insurance on Their Own	32.5	67.5

Source: Employee Benefits Research Institute

The results of the inequity can be clearly seen. Those workers who must use after-tax dollars to purchase health insurance are 24 times more likely to be uninsured than are those who are eligible for tax-free employer-provided coverage (Figure 5).[52] Significantly, the poor and minorities, who are less likely to have employer-provided insurance, are the most likely to be left without access to health insurance.[53] Thus, the perverse impact of our tax policies is to give a tax break on the purchase of health insurance to the most affluent in society and penalize those less well off.[54]

In addition to limiting access to health insurance, our tax policies also have an adverse impact on health care prices. By encouraging employer-provided coverage to the detriment of individually purchased coverage or out-of-pock- et payment, or both, our tax policy increases the trend toward divorcing the health care consumer from health care payment. Most health care consumers do not pay for their health care. On average, for every dollar of health care services purchased, 76 cents is paid by someone other than the consumer who purchased it.[55] As a result, consumers have little incentive to question costs and every incentive to demand more services.

Some critics argue that health care is not a commodity that a consumer can shop for like a car or a refrigerator. Certainly, an individual suffering a heart attack or involved in an automobile accident is not going to comparison shop for the best price. But less than 15 percent of health care is emergency in nature.[56] It is possible for consumers to shop for and compare prices of nonemergency services. For example, one study found that the cost of cataract surgery in Illinois ranged from $650 to $5,674 depending on the hospital; the cost of hernia surgery ranged from $404 to $4,329; and mammograms ranged from $35 to $178.[57] Studies in Georgia have shown similar variances in price. One study by the Georgia Department of Human Resources found that the cost of delivering a baby in different Atlanta hospitals varied from $1,177 to $3,100.[58]

Currently, most people are not cost conscious about health care purchases. However, there are numerous studies that show that health care consumers do make cost-conscious decisions when given a financial incentive to do so. For example, the RAND Corporation conducted a study of 5,809 people to determine whether the size of consumers' copayments had any effect on their health care decision- making. The study found that an individual with a 50 percent copayment spent 25 percent less on health care than an individual with no copayment.[59] Studies also show that, contrary to the assertions of some critics, reduced expenditures are not caused by individuals' forgoing truly necessary health care. Rather, the savings result from reduced utilization of optional services and cost-based selection among competing providers.[60]

Tax equity--treating individually purchased insurance and out-of-pocket health care expenditures the same as employee-provided benefits--will encourage health care consumers to become more involved in the health care system.

Individuals who purchase their own insurance are more likely to shop around for the best deal. And individuals who buy health care out-of-pocket are much more likely to make cost- conscious health care decisions.

The Heritage Foundation Plan

One of the first organizations to develop a health care reform proposal based on the relationship between taxes and health care was the Heritage Foundation. However, while it correctly diagnosed one of the major problems with our current health care system, it arrived at a curiously flawed conclusion. The Heritage Foundation plan has the following three parts.

1. Every resident of the United States would have to, by law, be enrolled in a plan that was adequate to cover major health care costs.

2. Families and individuals would receive tax credits to partially offset the cost of health insurance. The amount of the credit would be based on the family's health and health insurance spending compared to income.

3. The tax exclusion of company-provided health benefits would be phased out.[61]

While much of the analysis of that plan has focused on points two and three, the first part of the program has been generally overlooked. Yet it represents a profound departure from the American political tradition, which is all the more surprising coming from a leader of the "conservative" movement. The Heritage Foundation proposes a new "social contract" under which the government would "make it financially possible, through refundable tax benefits or in some cases by providing access to public-sector health programs, for every American family to purchase at least a basic package of medical care. . . . In return, government would require, by law, every head of household to acquire at least a basic health plan for his or her family."[62] The composition of the basic health plan would, of course, be determined by the government.[63]

That requirement would be enforced by compelling citizens to provide "proof of insurance" with their annual tax returns. Families that failed to comply would be fined or otherwise penalized.[64]

Such a proposal is a direct assault on the American ideal of individual responsibility. Michael Kinsley of the New Republic is correct when he says that

> philosophically, for all its talk of markets, Heritage, with this proposal accepts . . . the basic principle of socialism. In fact, it goes beyond socialism. Not only does the government have a duty to guarantee everybody affordable health care, but the government can require its citizens to obtain health care insurance whether they want to or not.[65]

There has been a growing trend in contemporary society toward laws designed to force individuals to take actions that the government has determined are "good" for them. Traditionally, conservatives have resisted such government nannyism. The Heritage Foundation's support for compulsory health insurance is a disturbing acceptance of government control over the personal lives of citizens--control that could easily be extended to many other spheres of life. Indeed, Stuart Butler, coauthor of the Heritage plan, approvingly compares his insurance requirement to mandatory seat belt laws.[66]

The Heritage Foundation's plan for health care tax credits also has problems. By making the tax credit refundable, the Heritage plan goes beyond simply allowing the tax deductibility of insurance or out-of-pocket health care expenditures. It calls for a new entitlement program, with tax dollars subsidizing the purchase of insurance. In addition, Heritage would phase out the health care tax credit at higher income levels. The program, therefore, is another income-transfer scheme. Eliminating the tax deductibility of employer-provided insurance while limiting tax credits to lower income families means substantially raising taxes for upper income taxpayers. Indeed, Kinsley estimates that an individual who earned $200,000 and had a $10,000 health insurance policy would face a $4,000 tax increase.

The Heritage plan would also allow extensive government regulation of the insurance industry. Among the insurance regulations endorsed by Heritage are guaranteed renewal, a prohibition on premium increases due to changes in health

status, limits on renewal premium increases, a requirement that all insurance coverage be fully portable, and rate limits for new enrollees (rates could be no more than 25 percent higher than the average premium charged similar families). The medically uninsurable would be randomly assigned to insurers, who would be required to provide coverage.[67] As discussed above, such regulations would almost certainly lead to higher insurance prices.

Finally, the Heritage proposal would address only one of the many problems facing our health care system. Heritage seems indifferent to other areas that need reform such as the overregulation of the health and insurance industries and the overinvolvement of government in paying for health care through Medicare and Medicaid.

Medical IRAs

Table 3
Cost Comparison: Medical IRAs vs. Traditional Health Insurance

Coverage	Cost ($)
Typical employee-purchased group premium for a family of four	4,500
Cost of catastrophic health insurance policy with a $2,000 deductible	1,800
Contribution to Medical IRA	2,000
Total Medical IRA/insurance costs for a family of four	3,800
Savings	700

Congressional Republicans have based their plan on the concept of Medical IRAs (called Medical Savings Accounts in their proposal).[68] Individuals would be exempted from taxes on money deposited in Medical IRAs, in the same way they currently pay no taxes on deposits to IRAs. Money to pay medical expenses could be withdrawn without penalty.

With such a program in place, employers could be expected to change the way they provide insurance. Rather than continuing to provide high-cost insurance, with low deductibles and extensive benefits, employers would provide each employee with an annual allowance of perhaps $2,000, which the employee could deposit in a Medical IRA. As Table 3 shows, such a change would actually save the company money. For medical expenses in excess of $2,000, the employer would continue to provide health insurance, but such catastrophic coverage would be relatively inexpensive. Individuals would be responsible for paying their own health care expenses under $2,000 from their accounts.[69] It should be noted that fewer than 12.5 percent of all insured individuals have annual claims in excess of $2,000.[70]

Unspent money in the accounts would accumulate and belong to the account holders. Before age 65, there would be a penalty applied to withdrawals for other than health care expenditures.

Medical IRAs will be particularly beneficial to low- income employees. Most current health insurance policies have deductibles, which can cause hardships for those with little discretionary income. Deductibles offer a perverse incentive for low-income workers. They are often forced to forgo preventive care or early intervention because they can't afford the deductible. Yet once the deductible is met, there is no incentive to limit additional expenditures. With an individual medical account, the incentive is to spend wisely throughout the year, rather than to punish the first expenditure of the year.[71]

Individual medical accounts would also be completely portable. One of the most serious problems of our current health care system is that insurance is so closely linked with employment. That means that individuals who loses their jobs or changes jobs are in danger of losing their insurance. Of the estimated 35 million Americans without health insurance at any given time, half are uninsured for four months or less, and only 15 percent are uninsured for more than two years.[72] With an individual medical account, people would continue to have funds available to pay for health care during temporary interruptions in employment.

Self-employed individuals would also benefit. Currently, lack of health insurance is 10 times greater among the self-employed than it is among those who work for others.[73] Medical IRAs would allow the self-employed to receive a substantial tax break for saving for their health care.

Medical IRAs would provide individuals with greater flexibility in the types of health care they could purchase. Such items as prescription drugs, dental care, and eyeglasses are frequently not covered by traditional employer-provided health benefit plans. Nor do most employer plans cover nontraditional health care professionals such as chiropractors and naturopaths. But people could use their individual medical accounts to pay for such services.

There would be no administrative overhead costs associated with payments from Medical IRAs.[74] That would reduce both the overall cost of health care and the paperwork burden on doctors.

By increasing America's savings rate, Medical IRAs would have a positive overall effect on the economy, and finally and most important, since the money would belong to the account holders, Medical IRAs would establish an incentive for consumers to act responsibly in making health care decisions.

The Goodman-Musgrave Plan

Medical IRAs are at the center of a comprehensive health care reform proposal by John C. Goodman and Gerald L. Musgrave.[75] For all the reasons discussed above, Goodman and Musgrave envision Medical IRAs as the key to establishing a consumer-oriented health care marketplace. In fact, their proposal goes much further than do other current proposals: they would use Medical IRAs to replace Medicare and Medicaid in the long term.[76]

Goodman and Musgrave join the Heritage Foundation in supporting changes in the tax treatment of health care. They would allow full deductibility of health insurance costs and health care spending, while limiting (although not necessarily eliminating) the tax exemption for employer- provided benefits. However, unlike the Heritage Foundation, Goodman and Musgrave would not phase out the deduction at higher income levels.[77]

The authors would subsidize the purchase of insurance for low-income families through refundable tax credits. As noted above, that runs the risk of establishing an entitlement program. However, by not phasing out tax deductibility for upper income people and by retaining (although capping) the deduction for employer-provided insurance, Goodman and Musgrave avoid the nakedly redistributionist aspect of the Heritage Foundation's plan.

Goodman and Musgrave also explicitly reject the Heritage Foundation's call for a requirement that all individuals purchase a minimum insurance benefit package. They note that "freedom of choice means the freedom to choose whether or not to purchase health care services at all."[78]

Going beyond tax issues, Goodman and Musgrave recognize the urgent need to deregulate the health care industry. Among other things, they would establish "medical enterprise zones" in underserved areas.[79] In those zones, unnecessary government regulations would be relaxed and the scope of practice for nonphysician professionals expanded.

Clinton on Health Care

President Bush's health care reform proposal seemed superficially to accept the concept of tax incentives as the key to expanding access to health care; it provided middle- and low-income people with a refundable tax credit or deduction of up to $3,750 for a family of four to cover the cost of health insurance.[80] However, by making the tax credit refundable, the Bush plan followed the Heritage Foundation's lead in creating another income-transfer program. The Bush administration contended that the tax deductions and credits would ultimately be extended to more than 95 million Americans.[81] Although such a program would be very expensive, the president offered no proposals for paying for the plan, beyond a vague call to reduce Medicare and Medicaid costs.

President-elect Clinton's health care plan is also hard to nail down. Clinton has repeatedly promised that his administration will enact a "national health care program" in his first 100 days. But the details remain obscure.

The official Clinton health care proposal calls for "universal coverage" through increased "business responsibilities."[82] Until recently, Clinton, the media, and the Bush campaign all called that option "play or pay."[83] But Clinton now says his proposal does not include a payroll tax,[84] thereby eliminating the "pay" portion. Since the president-elect still says he will require businesses to provide health insurance,[85] it can be presumed that he intends

a straight mandate. Yet analysts have estimated that the cost of having every business provide health insurance could put 9 million jobs at risk.[86]

The second element of Clinton's health care program is, unfortunately, all too clear. He calls for establishing a national Health Standards Board to set limits on total health care spending. Each state would establish limits on health spending that were within the national budget set by that board.[87] That is quite simply and openly the "global budgeting" concept imported from Canadian and European national health care systems. As discussed above, by restricting supply without limiting demand, global budgeting inevitably leads to rationing care, either explicitly, as it does in Great Britain, or implicitly through waiting lists, as it does in Canada. In addition, Clinton favors adopting new insurance regulatory requirements, including guaranteed issue and community rating.[88]

President-elect Clinton has been unwilling to embrace market-based health care reforms. His proposal appears to combine play or pay with Canadian-style global budgeting, and it would increase regulatory control of the insurance industry. On health care reform, as on so many other issues, Clinton gives supporters of free markets little to cheer about.

Conclusion

With the exception of the tax-incentive approaches, most major health care reform proposals would dramatically increase government involvement in the health care market place. The result would almost inevitably be increased costs and decreased access to care.

Only solutions that build on a free market in health care will ultimately be successful in controlling costs and increasing access to care. Government involvement in health care has been steadily increasing for 30 years, with disastrous results. It is time to seek solutions in the power of the free market.

Notes

[1] HR 1300 (Russo), S 2320 (Wellstone).

[2] Ibid.

[3] Aldona Robbins and Gary Robbins, What a Canadian-Style Health Care System Would Cost U.S. Employers and Employees (Dallas: National Center for Policy Analysis, February 1990).

[4] John Goodman, National Health Care in Great Britain (Dallas: Fisher Institute, 1980) chap. 6.

[5] John Goodman, National Health Insurance and Rural Health Care (Chicago: American Farm Bureau Research Foundation, 1992), p. 17.

[6] Anikka Schildt, "In Sweden, Equality Is Tinged with Inefficiency," Washington Post, August 16, 1988.

[7] Michael Walker, "From Canada: A Different Viewpoint, Health Management Quarterly, Spring 1989; Michael Walker, "Cold Reality: How They Don't Do It in Canada," Reason, March 1992; and Ed Haislmaier, Problems in Paradise: Canadians Complain about Their Health Care System (Washington: Heritage Foundation, February 19, 1992).

[8] "Canadians Cross Border to Save Lives," Wall Street Journal, December 12, 1990.

[9] "Cuts Hurt Canadian Health Care," Washington Times, June 24, 1991.

[10] Amity Shlaes, "Market Tests Britain's Health System," Wall Street Journal, January 27, 1988.

[11] For example, Canada has only 12 magnetic resonance im aging units, compared to more than 900 in the United States. There are 2.5 times as many CAT scanners in Seattle as in the entire province of British Columbia. Canada has only 11 open-heart surgery centers, compared to 783 in the United States. The United States has six times as many

lithotripsy units as Canada. United States vs. Canadian Health Care: An Information Package (Washington: National Committee for Quality Health Care, March 1990).

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[13] Gail Petrenko, "The Canadian Health Care System," Trends, April 1992.

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[15] "Health OECD, Facts and Trends," Health Affairs, Spring 1991.

[16] Michael Rachlis and Carol Kushner, Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It (Toronto: Collins, 1989).

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[19] Partnership for Health Care and Employment, Health Care's Road to Recovery: Address the Cost and Access Problems Now (Washington: PHCE, September 23, 1991).

[20] Employee Benefits Research Institute, "Special Report," April 1991, p. 10.

[21] "Study Says Democratic Health Care Plan Would Boost Annual Costs by $66 Billion," Wall Street Journal, January 10, 1992.

[22] John Goodman, Aldona Robbins, and Gary Robbins, Mandating Health Insurance (Dallas: National Center for Policy Analysis, February 1989).

[23] Health Benefits in 1991 (Newark, N.J.: KPMG Peat Marwick, November 1991), p. 4.

[24] S 1227.

[25] John Goodman, "Wrong Prescription for the Uninsured," Wall Street Journal, June 11, 1991.

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[32] "Perspective on Small Group Market Reform," Community Mutual Insurance Company, September 1991. See also "Health Committee Testifies on Small Group Reform," Actuarial Update 20, no. 7 (August 1991).

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[43] Ellwood and Etheredge, p. 10.

[44] Ibid.

[45] Jackson Hole Initiative, p. 5.

[46] Ibid.

[47] Ellwood and Etheridge, p. 9.

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