CATO HANDBOOK FOR CONGRESS

Policy Recommendations for the 108th Congress

CATO INSTITUTE
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27. Private Health Care

Congress should

- offer a simplified set of flexible medical savings account options to all Americans;
- provide a tax credit option for taxpayers who choose to purchase health insurance that is not sponsored by their employers;
- expand consumer choices that increase market-based accountability of health plans; and
- improve access to health care through incentives to purchase less-comprehensive insurance, expand high-risk pool coverage, finance charitable safety net care, and deregulate state insurance regulation.

In the past two years, Congress finally may have exhausted its exploration of incremental health care proposals that lacked any consistent and coherent vision of free-market health care reform. The 107th Congress ultimately backed away from reconciling yet another set of different House and Senate versions of so-called patient's bill of rights legislation. Congress could not decide whether to herd more low-income uninsured Americans into Medicaid coverage or to accomplish income redistribution objectives through refundable tax credits for health insurance. The saving grace for a ''do-nothing'' Congress was that it did nothing to substantially expand federal control over the U.S. health care system. However, it also failed to begin to restore fundamental control of health care decisionmaking to individual consumers within a competitive free market.

Freeing Medical Savings Accounts from a Regulatory Lockbox

One of the primary factors driving health care costs higher has been the increased share of medical bills paid by third-party payers such as private health insurers, employers, and government health program admin-

istrators. On average, more than three out of every four dollars used to purchase health care are actually paid by someone other than the consumer who incurs the bill.

The centerpiece of market-oriented health care that can reverse this trend remains medical savings accounts (MSAs). MSAs combine two elements—a savings account controlled by the insured individual to be used to pay for routine health care expenses and a high-deductible (catastrophic) insurance policy to cover more substantial health care needs. With MSAs, a much smaller share of health care spending is funneled through third-party insurance. MSAs provide workers strong market incentives to control the costs of their health care, because account holders are effectively spending their own money for routine health items. That, in turn, stimulates real cost competition among and price disclosure by doctors and hospitals.

The 1996 Health Insurance Affordability and Accountability Act authorized up to 750,000 ''tax-qualified'' MSAs over a four-year period (later extended to December 31, 2003). Unlike previous MSAs, those so-called Archer MSAs featured tax-deductible treatment of MSA deposits and tax-exempt treatment of investment earnings accumulated with the MSAs. However, the potential of Archer MSAs has been hampered by eligibility limits and other design flaws mandated by HIPAA.

The next Congress should authorize MSAs permanently and open MSA eligibility to anyone covered by qualified high-deductible insurance. Market-oriented MSA rules also should provide more flexibility in deductible levels, contribution amounts, and fund withdrawal options. The best way to bring down health costs and improve health care quality remains a simple one—let workers and patients control more of their own health care dollars.

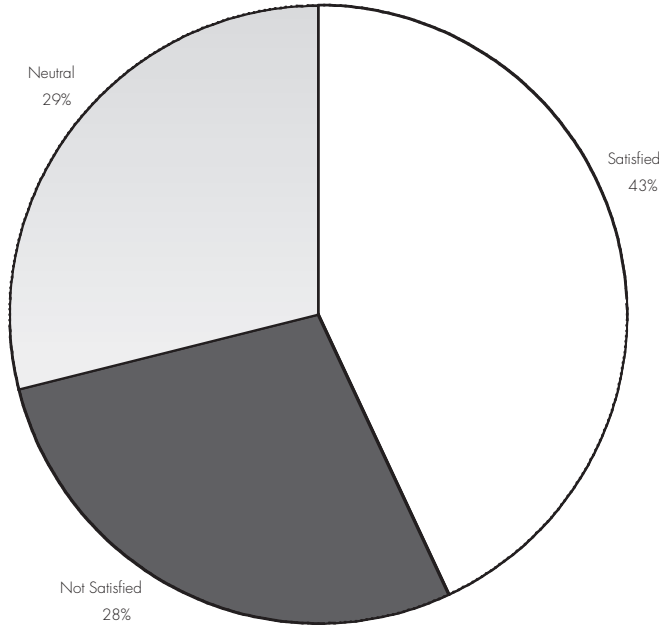
Facilitating Defined-Contribution Employer Health Benefits

A growing number of employers are beginning to offer defined-contribution-style (DC) health benefits plans, in which the employer purchases less-comprehensive, high-deductible group insurance coverage for workers covered by the plan and then makes cash contributions to those workers' individual health accounts. DC plans help employers cope with rising health insurance costs by capping their total health benefits contributions, increasing employee cost sharing, and empowering workers to handle more routine health care decisions.

Fewer than half (43 percent) of workers covered by employer-sponsored insurance (ESI) are satisfied with the overall performance of their current health plan, according to a Watson Wyatt Worldwide survey in 2001 (Figure 27.1). Fewer than half (48 percent) trust their employer to design a health plan that will provide the coverage they need, and approximately the same number of employees think better health plans are available for the same cost (Figure 27.2). Almost 4 of 10 employees want their employer to contribute a fixed-dollar amount toward the premium for any health plan—even if it means the employees have to find their own health plans.

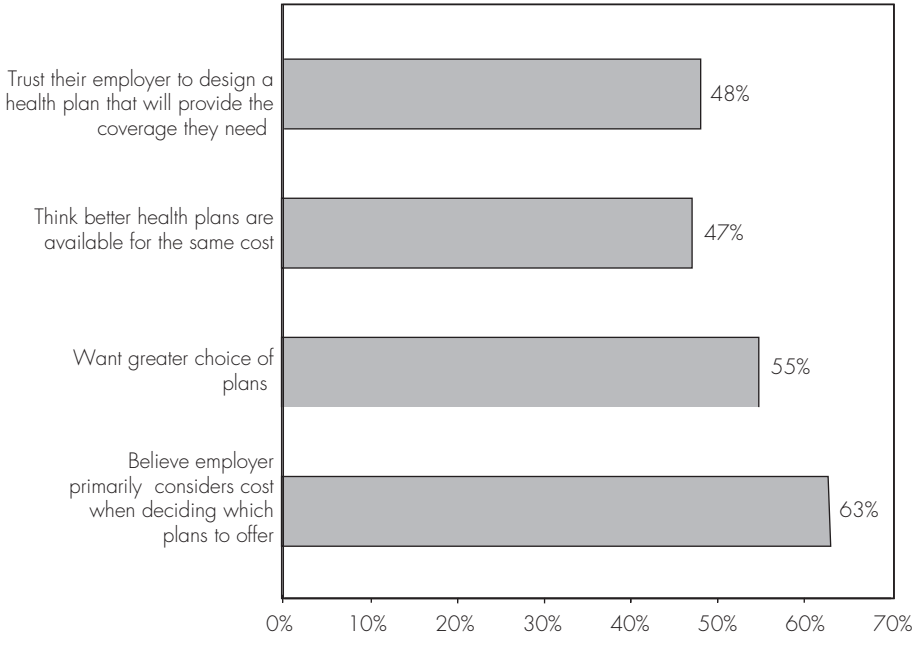
A ''purer'' form of DC plan would allow employees to select their own individual insurance coverage, with the assistance of their employer's original contribution. Whether individual employees pay just the extra cost of additional out-of-pocket health spending or the extra cost of more generous insurance coverage as well, DC plans provide incentives for

Figure 27.1
Most Employees Are Less Than Satisfied with Health Plan Performance



SOURCE: Based on Watson Wyatt, ''Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management,'' www.watsonwyatt.com/research/resrender.asp?id+W-446&page3.

Figure 27.2
Employees Want More Options and Greater Involvement in Selecting a Health Plan



SOURCE: Based on Watson Wyatt, "Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management," www.watsonwyatt.com/research/resrender.asp?id+W-446&page3.

people to compare the value of the health care they receive with that of other goods and services they might want.

DC plans might provide a halfway house in the transition from comprehensive ESI to high-deductible MSA plans. Value-conscious employers and employees could insist that insurers ''spin off'' (not insure) items about which little uncertainty exists or for which the typical treatment cost is relatively low compared with the paperwork required to process the claim. Whereas MSA plans rely on much higher deductible levels for accompanying catastrophic insurance policies and treat all insured services equally, two-tiered DC plans could provide certain ''preventive care'' health services with first-dollar coverage, while others might not be covered at all.

Despite the potential benefits of two-tiered DC plans, as well as recent tax guidance issued by the Internal Revenue Service clarifying how accumulated balances in an individual employee's health reimbursement

account may be treated when rolled over at the end of a year, several regulatory barriers to the future growth of DC plans still need to be removed.

First, ''pure'' DC plans for fully insured employer groups, in which an employer distributes defined health benefits contributions to each eligible employee and allows employees to purchase their own individual or non-employer-group insurance coverage, run the risk of being regulated inconsistently. They might be treated both as employee welfare benefit ''group'' plans and as ''individual'' health plans under state law.

Congress should clarify the regulatory treatment of this kind of DC plan so that it is not considered an ''employee welfare benefit plan'' for regulatory purposes under the Employee Retirement Income Security Act. However, such plans or funds should retain their ''group'' tax exclusion benefits under the Internal Revenue Code. One possible version of such hybrid treatment (group for tax purposes, individual for regulatory purposes) was proposed in the Health Care Act of 2001 (H.R. 2658).

Second, the defined contributions that employers make to individual employees in pure DC plans, to be used to purchase individual health insurance coverage, should be allowed to vary on the basis of health status in the event the employer uses an approved risk-adjustment mechanism. Congress should amend HIPAA rules to allow employers to make larger contributions to workers with poorer health status to offset the higher premiums they face when they seek to purchase individual coverage.

Third, recent IRS guidance regarding the tax-free rollover status of employer contributions to health reimbursement accounts still does not allow accumulated funds to become vested for other non-health-spending purposes. Nor does it allow employees to contribute their own money to such tax-advantaged accounts. To a large extent, allowing annual rollovers of flexible spending account (FSA) fund balances, or expanding the availability of MSAs, would bypass most of this problem if Congress does not address it more directly.

Tax Equity and Efficiency

MSAs and DC health plans provide a foundation for free-market health reform, but Congress also needs to enact more fundamental changes in the tax treatment of health care benefits. The tax system should promote economic efficiency and be perceived as fair. Its compliance and administrative costs should be kept to a minimum. Tax policy proposals that try

to target more narrow objectives must be structured to reinforce, not undercut, those fundamental principles.

Federal tax law excludes the cost of employer-sponsored health insurance benefits from the taxable income of individual workers. Many employers also offer their employees tax-exempt FSAs for health care reimbursements. However, those job-based tax benefits for health care spending put employers, instead of employees, in charge of selecting health care benefits. Special tax treatment of ESI via the so-called tax exclusion forces many working Americans to accept the only health plan offered by their employer or pay higher taxes.

The tax exclusion also raises the comparative after-tax price of other non-employer-based insurance alternatives. Although similar tax subsidies are available to the self-employed, the tax exclusion provides no assistance at all to other individuals (such as Americans working in firms that do not provide health insurance) who might wish to purchase health insurance on their own.

The tax exclusion distorts health care purchasing choices by favoring the financing of medical services through insurance and providing the greatest tax benefits for the most costly versions of employer-sponsored coverage. It encourages workers to think that someone else (their employer) pays for their health care, and it reduces their sensitivity to the cost of health insurance choices. The tax exclusion disconnects the consumption decisions of insured workers and their families from the payment decisions of employers and their insurers. Tax subsidies for health insurance overstimulate the demand for health care and, perversely, increase its total cost, creating net welfare losses estimated at 20 percent to 30 percent of total insurance spending.

The current tax subsidy for health insurance is inefficient and unfair. It should be reformed to place individuals, not employers or government, in charge of choosing something as personal as health care.

The best way to remove tax policy distortions from the health insurance market would be to eliminate tax subsidies for employment-based health insurance altogether. Implementing a flat income tax or a national sales tax would provide the best comprehensive solution. Fundamental tax reform would render neutral the federal government's tax treatment of all goods and services, including health care. Employer-paid health benefits either would be treated as taxable income earned by employees (flat tax) or would be subject to a sales tax like other goods and services (national sales tax).

However, repeal of the tax exclusion would need to be phased in gradually and be accompanied by offsetting reductions in marginal income tax rates and increases in income tax bracket thresholds, in order to minimize economic distortions and return the money to the American workers who earn it.

Absent a broad restructuring of the tax code, the next-best policy would be to offer a new federal tax credit option, most likely amounting to 30 percent of the cost of qualified insurance coverage. The tax credit option would not eliminate the current tax exclusion; it would provide a competitive alternative for workers to choose in place of the tax exclusion. It would encourage a more gradual transition to other forms of private insurance coverage. The tax credit option also would be made available to other individuals and families that currently do not qualify for the tax exclusion because they lack access to ESI coverage.

Employers that continue to offer ESI should be required to report the value of the employer-financed share of that coverage to individual employees on their regular periodic pay statements and annual W-2 forms. The default setting for such disclosure would assume that workers in employer-group plans are community rated within the firm and the employer contributions for coverage are identical for each worker (such as the periodic equivalent of the firm's per employee COBRA premium). In the event that employers were allowed to adjust health plan contributions to reflect factors specific to individual workers, they could report those different amounts instead.

The new tax credits would be assignable to insurers and advanceable, but not refundable. The maximum tax credit available to any eligible individual would be no greater than that individual's total federal income tax and FICA payroll tax liability (including both the employee and employer shares) for the previous calendar year. Only taxpayers would receive tax credit ''relief'' for health insurance costs.

The net effect of the above tax reform would be to encourage workers and their families either to move from ESI coverage to individually purchased insurance or to ensure that the ESI plan they select represents the best competitive value they can find.

Congress should consider using the new tax credit option to leverage other market-opening reforms. In that case, consumers wishing to use the tax credit would have to purchase an insurance package that covered a minimum set of health services and included a minimum, but significant, front-end deductible (along with maximum out-of-pocket ''stop-loss'' lim-

its). Qualified insurance policies might provide separately priced guaranteed renewal options in return for exemption from HIPAA's guaranteed renewal requirements. Those policies also should be exempt from individual state benefit mandates. New voluntary purchasing pools could be authorized to accept tax credit funds to pay for such qualified insurance in return for federal preemption of state benefit mandates, fictitious group laws, or rating laws that would otherwise interfere with their operations.

Providing a new tax credit option could jump-start the evolution toward an employee benefits environment in which workers more directly control their health care benefits and insurance choices. It would ensure sufficient consumer demand for individually selected insurance arrangements and provide a competitive alternative to ESI coverage.

Improving Access to Health Care for the Low-Income Uninsured

Any new tax credits for health care should not try to finance comprehensive insurance for all uninsured, low-income Americans. Most refundable tax credit proposals are designed to award tax ''cuts'' to individuals who pay little, or no, federal taxes. But endorsing a new round of income redistribution and federal spending via the tax code (in the name of health care) is contradictory and counterproductive. Refundable health tax credits blur necessary policy distinctions between how to set the appropriate level of income-based welfare assistance and how to neutralize the many distortions caused by our complex tax system. The politics of refundable tax credit proposals also has unfortunately steered recent health care debates away from broad, individual empowerment tax reforms and toward a narrow, cramped version of targeted handouts to smaller slices of the low-income uninsured population. The alternative budgetary end game of traveling down the road to a universal fixed-dollar tax credit is likely to involve financing new subsidies for nontaxpayers by reducing the current health insurance tax benefits available to higher-income Americans (in other words, the old politics of trying to soak the rich to subsidize the poor).

Refundable tax credits combine bad tax policy, bad welfare policy, and bad health policy. They reinforce the mistaken stance of those who argue that cuts in marginal tax rates are somehow ''unfair'' when they provide most of their benefits to those who pay the largest share of federal income taxes. Refundable credits also are prone to carrying the lumpy baggage of complex income-based, phase-out levels; tight restrictions on the con-

tents of eligible health benefits packages; and narrow rules for eligible insurers.

Making health tax credits refundable would endorse expansion of current taxpayer-financed ''entitlements'' to health insurance coverage. It would adopt the view that health insurance is a ''merit good'' for everyone and that necessary access to health care cannot be adequately financed without even greater subsidies from taxpayers for insurance coverage. Many lawmakers who salute the remarkable benefits gained from limiting the magnitude and duration of cash assistance to low-income beneficiaries on the welfare rolls nevertheless appear poised to dole out a new round of permanent ''welfare'' checks to the working poor, hidden beneath a refundable health tax-credit label.

For low-income individuals lacking access to health insurance, the better policy solutions include safety net reforms that strengthen state high-risk pools and encourage charitable contributions to provide health services through nonprofit intermediaries. Dollar for dollar, investing in safety net assistance that directly delivers care to the uninsured is more effective and productive than trying to coax them to purchase health insurance with modest tax subsidies. In the long run, improving the quality of education that lower-income individuals receive, expanding their personal control of health care decisions, and reversing regulatory policies that increase the cost of their health care will yield even greater returns in improved health outcomes.

Managed Care and Consumer Empowerment

Although the growth of managed care insurance coverage during the 1990s helped to restrain the rate of growth of health care costs, consumers increasingly became dissatisfied with managed care's limits on covered treatments and restrictions on their choice of physicians. Various ''patient's bill of rights'' (PBOR) measures have been proposed in Congress to respond to (or at least exploit) those cost and quality conflicts.

In the 107th Congress, both House and Senate bills advanced that would have extended the tentacles of federal regulation more tightly over health insurance arrangements and health care delivery. A multitude of new federal commands was buttressed by the usual vague, undefined terms and weasel words, sure to expand bureaucratic discretion and control in future rounds of reinterpretation and elaboration. Even without more explicit rights to sue health plans over coverage denials, approval of PBOR mandates would have opened the door to federal micromanagement of

complex health care decisions and provided the foundation for lawsuits based on alleged violations of mandatory standards.

Ironically, while Capitol Hill politicians again reached a dead end in negotiations over a final PBOR bill, they were essentially still fighting the last war. The marketplace had moved on. The pure vision of HMO-style health care failed several years ago. HMOs reduced costs primarily by gaining bargaining leverage and squeezing the wallets of providers on fees, but their claims of evidence-based health care management and cost-saving preventive care often were more illusion than reality. Other forms of managed care became more widespread and more attractive to employers. Employers shifted their health plans to preferred provider organizations with broad networks and fewer limits on access to care. When workers insisted on more choices and fewer hassles, their employers generally responded. However, part of the price of loosened management of health care services may have been the recent return of annual double-digit percentage increases in health insurance premiums.

The most immediate victims of PBOR-style regulation would be the consumers who don't want, or cannot afford to pay for, the type of minimum contract terms that the legislation would mandate. Raising the cost of health insurance and regulating away low-cost HMO options will hurt low-income workers the most. They will either have to pay the higher price of upper-middle-class medical care expectations or have to go without any insurance at all. Price-sensitive small employers who could no longer find low-cost HMO options also would be squeezed out of the insurance market.

Instead of offering consumers another set of unreliable third-party guardians (regulators, independent medical reviewers, and courts), Congress should emphasize greater tax equity for all health care purchasers and expanded pooling options outside the workplace so that disgruntled consumers could choose and control the types of health plan and benefits packages for which they are willing to pay.

A policy environment friendlier to value-driven consumer choice would hold managed care insurers and self-insured employers more accountable to their true customers. Consumers would rely on voluntary contracts and competitive markets, instead of random lawsuits, to stimulate better service, relevant disclosure, benefits flexibility, and health care innovation. Or they would switch insurers.

Legitimacy and acceptance of after-the-fact results in health care require before-the-fact opportunities to choose. Many consumers may not want

to manage personally most details of their health care decisions, but they should get to decide who will decide for them.

Insurers or employers that still choose to more actively manage health care decisions or supervise in-network providers should be exposed to vicarious liability for medical malpractice and other negligent treatment decisions. Liability rules should clarify the differences between contractual obligations (delivering what it promised by the written terms of a health insurance policy) and tort liability (providing compensation for personal injuries and other losses arising from care rendered by health care providers under the contract between a health plan and a purchaser of its coverage). Augmenting ERISA contract remedies for wrongful denial of coverage could be handled through early offer settlement incentives and a worker's compensation–like schedule of recoveries tied to the cost of denied benefits.

For the last six years, Congress has remained both fixated on and stalemated over how to hold managed care plans more accountable for adverse medical treatment outcomes but avoid crushing them under an avalanche of personal injury lawsuits. If the next Congress cannot remain away from the PBOR bargaining table, it should at least reconsider the applicable standard that it sets for external review of coverage decisions. Review should focus on interpreting and enforcing the actual contractual terms of a particular health plan—rather than on making de novo ''expert'' judgments about what constitutes ''medically necessary'' treatment according to a uniform standard of care.

Restoring the role of consensual contracts, instead of expanding the role of adversarial tort lawsuits and political micromanagement, would improve the range of competitive health care choices for consumers and encourage better monitoring of health care quality.

Conclusion

We cannot afford to allow the market vision of health care reform to be dimmed and obscured by cut-rate compromises that lead to a slow, steady drift toward centralized, politicized control of health spending decisions. Every calculated attack on private health insurance markets should be resisted before a series of ''small'' proposals steadily accumulates to make private coverage ever more expensive and difficult to obtain.

Health care costs will remain too high, the value of health insurance too inadequate, and the quality of health care too low until we restore a genuine free market in health care, from cradle to grave.

Suggested Reading

Bunce, Victoria C. ''Medical Savings Accounts: Progress and Problems under HIPAA.'' Cato Institute Policy Analysis no. 411, August 8, 2001.

Miller, Tom. ''Improving Access to Health Care without Comprehensive Health Insurance Coverage.'' In *Covering America: Real Remedies for the Uninsured.* Edited by Elliot K. Wicks and Jack A. Meyer. Washington: Economic and Social Research Institute, 2002.

_____. ''Nickles-Stearns Is Not the Market Choice for Health Care Reform.'' Cato Institute Policy Analysis no. 210, June 13, 1994.

_____. ''A Regulatory Bypass Operation,'' *Cato Journal* 22, no 1 (Spring–Summer 2002).

Miller, Tom, and Gregory Conko. ''Getting beyond the Managed Care Backlash.'' *Regulation* 21, no. 4 (Fall 1998).

Miller, Tom, and Scott E. Harrington. ''Competitive Markets for Individual Health Insurance.'' *Health Affairs*, October 23, 2002.

Morreim, E. Haavi. ''Defined Contribution: From Managed Care to Patient-Managed Care.'' *Cato Journal* 22, no. 1 (Spring–Summer 2002).

_____. ''The Futility of Medical Necessity.'' *Regulation* 24, no. 2 (Summer 2001).

Scandlen, Greg. ''Legislative Malpractice: Misdiagnosing Patients' Rights.'' Cato Institute Briefing Paper no. 57, April 7, 2000.

Tanner, Michael. ''Medical Savings Accounts: Answering the Critics.'' Cato Institute Policy Analysis no. 228, May 25, 1998.

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