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MEMO

The Heritage Foundation

To: Policymakers

From: David M. Mason, Director, Executive Branch Liaison

Date: October 2, 1990

Subject: The Pepper Commission

America's health care system is in trouble. Congress needs to enact reforms that create a consumer-oriented, market-based health care system. What it does not need is the changes recommended by the Pepper Commission.

In this Backgrounder, Heritage Policy Analyst Edmund F. Haislmaier reviews the work of the Pepper Commission, which he says is out of touch with the real problems facing the health care system. By proposing more federal spending, taxes, and regulation, Haislmaier argues that the Commission's recommendations "pour gasoline on the inflation fire by legislating access to health and then passing the tab to business and the taxpayer."

Haislmaier calls for a politically and economically stable health care system that contains incentives to curb the escalating costs of medical care. He proposes giving consumers control over the money spent on their health care, and recommends changes in tax codes to allow all Americans access to medical care and health insurance.

I trust you will find this Heritage Backgrounder useful in your efforts to reform America's ailing health care system.

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The Heritage Foundation Backgrounder

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THE PEPPER COMMISSION'S MISGUIDED SOLUTION TO AMERICA'S HEALTH CARE PROBLEMS

INTRODUCTION

The U.S. Bipartisan Commission on Comprehensive Health Care, named the Pepper Commission after its congressional sponsor and first chairman, the late Florida Democrat Claude Pepper, released its final report this week.[1] While this final version contains some additions and modifications, its basic recommendations are the same as those which received widespread criticism when outlined in the Commission's preliminary report issued this March. These recommendations show the Commission to be out of touch with the real problems of the United States health care system, and impractical in its suggested solutions.

The Pepper Commission was charged with finding ways to provide uninsured Americans with insurance coverage and access to health services, and to improve the financing of long-term care. A majority of Commission members recommended five steps to achieve those goals:

1) **Require employers to provide** health insurance or pay a new payroll tax to pay for government-provided insurance;

2) **Establish a federally-mandated basic** minimum package of health benefits for all insurance policies;

1 *A Call for Action: The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, Final Report*, September 1990.

3) **Introduce a redesigned and expanded** public assistance program similar to Medicaid for all lower income Americans and families lacking employer-provided insurance;

4) **Place substantial new restrictions** on how health insurers write policies and conduct business;

5) **Create a new federal entitlement program** to pay for most of the long-term care costs of middle-income and affluent retirees, whose assets or income currently make them ineligible for public assistance through Medicaid.

The recommendations in the Commission's final report also come with an even higher price tag than the staggering $66.2 billion per year projected in its March preliminary report. The Commission now estimates that its recommendations will cost taxpayers $68.8 billion per year when fully implemented. Complying with the proposed changes would impose additional net costs of $14.7 billion per year on American businesses.

When the Commission issued its preliminary recommendations, it was roundly criticized both by its own dissenting members and by many in Congress – including liberal Democrats as well as conservative Republicans – for failing to specify how the federal government would finance the enormous cost of its proposals. In its final report, the Commission again ducks the question by failing to recommend any financing methods. All it does is list a virtual cornucopia of tax increases, inviting Congress to chose which to enact.

There are several reasons why Congress should discard the Commission's report and look elsewhere for answers:

First, the costs of the proposed solutions are unacceptably high. Moreover, the tab could hardly have been presented at a worse time. The Commission calls for $68 billion a year in new federal spending and taxes just when congressional and Administration budget negotiators are desperately seeking ways to close the huge budget deficit. Furthermore, it is irresponsible for the Commission to propose massive new government spending and taxes, onerous new regulations on business, and a sharp increase in worker payroll taxes at a time when the U.S. economy totters on the brink of recession. Even without an economic downturn, the Commission admits that the payroll taxes it proposes could cost 50,000 jobs. The Hoover Institution's John Cogan, the only economist on the Commission and a labor specialist, maintains the losses would be far in excess of that, reaching as high as 1.4 million jobs.

Second, the proposed changes would do nothing to curb the present escalation in health care costs. Indeed, they would use new tax revenues to throw more fuel on the fire.

Third, the Commission's expensive recommendations would create a health system that would be politically and economically unstable. Rather than offering a lasting solution to the problems of health care financing, the Commission's proposals would ignite new problems requiring new solutions. Ultimately, mounting problems would force Congress into either accepting

true market-oriented reforms or creating a fully nationalized health care system.

Predictable Prescription. Regrettably, the Pepper Commission is yet another report that concludes with Congress's predictable prescription of more federal spending, taxes, and regulation. While the problems in America's health care system are indeed real and serious, simply throwing more money at them will not make them go away. A true solution must focus on changing the basic underlying incentive structure that governs the decisions of health care consumers, providers, and insurers. Needed are new incentives that discourage, rather than encourage, over-pricing, over-consumption, over-prescribing of marginally useful procedures, and waste and inefficiency in the purchase and delivery of medical services.

Rather than trying to extend the employer-provided health insurance system to all Americans, Congress needs to recognize that it is this system, and particularly the misguided tax policies and regulations governing it, that generates the perverse incentives and resulting problems. Congress thus should enact reforms in health care tax policy that put health care dollars and decision-making power back in the hands of consumers. Reforms also must provide direct subsidies to Americans with low incomes or high medical costs to increase their purchasing power in the medical marketplace and thus enable them to buy the care and insurance they need.[2]

Creating a system that encourages consumers to purchase medical care and health insurance directly, while allowing them to pocket any resulting savings, would generate powerful and positive incentives. All parties concerned – consumers, providers, and insurers – would be directly rewarded for seeking or providing quality health care at reasonable prices.

Encouraging Private Insurance. In the area of long-term care, Congress must realize that its job is not to protect the assets of affluent retirees by imposing new taxes on working Americans to fund the cost of their care. Asset protection is a job for private insurance. Congress can and should enact tax reforms making it easier for Americans to use such private mechanisms to protect themselves against the potential costs of long-term care.

Congress must undertake reforms that replace the current perverse incentives in the health care system with positive incentives to encourage economical use of health care services and assure help for those who need it most. Only then will all Americans have access to affordable health care. The Pepper Commission does nothig to advance that day.

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2 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989), and Stuart M. Butler, "Using Tax Credits to Create an Affordable National Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990.

THE COMMISSION'S RECOMMENDATIONS

The Pepper Commission recommends a package of steps to provide insurance and access to medical care for all Americans. These steps would have a major impact on business, insurers, and taxpayers. In addition, it recommends a sweeping new long-term care entitlement program.

1) Mandated Employer-Paid Coverage

Employers would be required to provide health insurance coverage for all their workers, and for non-working dependents of those workers. Firms could do this either by purchasing private insurance themselves or by paying a 7 percent payroll tax to fund a new federal government plan which would provide the insurance. Employers would be required to pay at least 80 percent of the cost of either private insurance premiums or the public plan, and workers could not be required to pay more than 20 percent. Initially, this "play or pay" mandate would only apply to employers with 100 workers or more. During the first several years of the new system, however, smaller employers would be encouraged by various incentives to purchase similar coverage for their workers. Smaller employers would only become subject to the same mandate if these incentives did not work.

Health insurance for low-income individuals would be further subsidized, with the subsidies varying according to income. Individuals and families with incomes below the federal poverty threshold would pay no premiums, nor could they be charged deductibles or coinsurance for covered services. Coinsurance is the percentage of the bill which the patient pays in addition to any initial deductible. Individuals and families with incomes between 100 and 200 percent of the poverty threshold would pay a share of the premiums, deductibles, and coinsurance according to a sliding scale based on their incomes. Eventually, all Americans would be required to obtain coverage either from their employers or from the federal plan.

2) Expanded Public Assistance

The existing federal-state Medicaid program would be replaced by a new program, with eligibility divorced from welfare programs. This new program would provide health insurance coverage to the poor and unemployed, including those now covered by Medicaid, as well as the self-employed and the employees of firms choosing to pay a payroll tax rather than to provide their workers with private insurance. This new program would be a federal entitlement with uniform federal rules and benefits. As is now the case with Medicaid, states would pay a portion of the cost of the new program. States would administer the program, subject to federal guidelines and regulations.

Premium and cost-sharing rules for the new government program would be the same as those for the mandatory employer-provided insurance envisioned by the Commission. Under the new public program, individuals and families with incomes below the federal poverty threshold would be exempt from

paying premiums or any cost-sharing (deductibles or coinsurance) for covered services. Those with incomes between 100 and 200 percent of poverty would pay a share of the premiums and cost-sharing according to a sliding scale based on income. The new program would pay health care providers according to current Medicare rates or new rates determined using Medicare rules.

3) The Minimum Benefit Package

A new federally-specified minimum health insurance benefits package would be established. This package would supersede all existing state laws governing the content of health insurance polices. Thus states no longer would be allowed to require insurers to provide more generous benefits than the federal minimum package. Private insurers could, however, still offer more generous coverage on a voluntary basis.

Employers who chose to continue providing their workers with private insurance, whether through traditional insurance or managed care plans, would be required to provide coverage meeting at least this new minimum standard. The same minimum package would be provided to those enrolled in the new public plan, although lower-income individuals and families would be given more generous coverage.

The required minimum benefits provision would include all hospital services, surgical services, physician office visits, diagnostic tests, and preventive services (including prenatal and well-baby care and various cancer screening tests). Mental health services of up to 45 inpatient days and 25 outpatient visits per year also would have to be included. The annual deductible could be no more than $250 for a single individual, or $500 for a family.

Coinsurance charges in general could not exceed 20 percent for any of the covered services. The exceptions to that general rule would be a 50 percent limit on coinsurance for outpatient mental health visits and no deductibles or coinsurance at all for prenatal care, well-baby care, or cancer screening tests.

Under the Commission's scheme, all insurance would in addition be required to include a "stop loss" or "catastrophic" feature, limiting an individual or family's out-of-pocket payments for deductibles and coinsurance to $3,000 per year.

4) New Insurance Regulations

The federal government would establish new regulations governing the way health insurance companies do business. Again, these would supersede existing state laws.

Insurers would be prohibited from applying pre-existing condition exclusions. This means insurers could no longer limit or refuse coverage for the costs of treating a medical condition the policyholder had at the time he applies for insurance, or had been treated for in the past.

Insurers would be required to accept all groups wishing to purchase health insurance. In the case of small groups, such as employees of a small company, insurers would be required to set premium rates on the same terms for all groups within specified areas and would be prohibited from selectively increasing rates for a particular group or individual. Insurers would, however, be allowed to require specified minimum enrollment periods as a condition of providing coverage (to prevent policyholders buying a low cost policy, and then switching temporarily to a more generous plan when they wanted an expensive service).

Insurers in the small group market would be required to include those groups in the managed care systems they offer larger employers, allowing them to choose between traditional insurance and Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs).

5) The Five-Year Phase-In Period

The employer mandates, insurance regulations, and new public program would be put into effect according to a five-year timetable.

Year 1: Coverage under the new public program is extended to all pregnant women and children up to age six who are not currently covered by Medicaid or private insurance.

The new regulations on private insurers take effect.

Year 2: The new public program is expanded to include uncovered children up to age eighteen.

Unincorporated businesses are allowed to deduct the cost of health insurance fully from taxable income.

Firms with fewer than 25 employees and average payrolls below $18,000 per worker receive a temporary 40 percent refundable tax credit toward the purchase of minimum coverage.

Year 3: All firms with more than 100 employees are required to provide the minimum package of health insurance to all full-time and part-time workers and their non-working dependents, either by purchasing private insurance or by paying the payroll tax for coverage under the public program.

Year 4: Employers with 25 to 100 employees become subject to the full mandate if at least 80 percent of their workers (and their dependents) have not yet been provided by them with the basic minimum health insurance coverage, through private insurance or the public program.

Year 5: Firms with fewer than 25 employees become subject to the mandate if they have not yet provided at least 80 percent of their workers (and their dependents) with the basic minimum

health insurance coverage, through either private insurance or the public program.

All special tax credits or subsidies for buying health insurance available to small businesses are eliminated at the end of the year, except for firms "with ten or fewer workers at extreme financial risk."

All remaining individuals not covered by either the public program or private insurance become eligible for the new public program.

6) Long-Term Care Program

The Commission recommends that the federal government establish a new long-term care entitlement program, financed mainly by a social insurance system. The program would be phased in over four years and serve all Americans needing long-term care, regardless of income. It would cover the first three months of nursing home care, and home and community-based care of up to 400 hours per year for an unlimited period. This new program would be financed completely by the federal government, with the states administering it according to the federal guidelines.

Beneficiaries would be required to pay either 20 percent of the actual cost of their care or 20 percent of the national average cost, whichever is lower. This coinsurance would be reduced for individuals with incomes between 100 percent and 200 percent of the poverty threshold, and eliminated entirely for those below the poverty line.

For care outside a nursing home, the program would use a "case manager" system to control costs. The federal government would fix and regulate provider reimbursement rates both for home and community-based care and for nursing home care.

Sharing Costs With States. For persons with nursing home stays beyond three months, a second level of assistance would be available, with the cost shared by the states as well as by the federal government. Under this second tier of coverage, the new program would continue to pay nursing home costs after beneficiaries had spent their income and assets. However, beneficiaries would be allowed to retain certain assets and resources. Specifically, single individuals could retain their home and $30,000 in other, non-housing assets. They would also be allowed to keep $100 a month to meet personal needs, and for the first year of a nursing home stay, they could retain 30 percent of their income to cover the cost of maintaining their own residences. Beneficiaries would be required to use all other income and assets above these limits to defray the cost of their care. The same rules would apply to couples, with the exception that they could retain $60,000 in non-housing assets. In the case of nursing home patients with a healthy spouse, they would be allowed to retain income equal to 200 percent of the poverty level for a couple (or a total of about $16,900 in 1990), to support the healthy spouse living in the community.

Under the Commission's proposal, new federal tax regulations would apply to employer-provided private long-term care insurance. These regulations would give such long-term care policies the same preferential tax treatment now given to employer-provided acute-care health insurance. The federal government also would set new standards for private long-term care insurance policies.

7) Additional Provisions in the Commission Report

- The existing Medicare program would be restructured to make it compatible with the new federal minimum requirements for health insurance policies.
- The federal government would develop national guidelines for physician practice and standards of care.
- The federal government would develop a uniform national data system to collect information on all doctors' visits, hospital stays and procedures, regardless of where they occur or how they are paid for.
- The federal government would develop and test better methods of assessing and assuring the quality of medical care.
- The federal government would develop an expanded network of local review organizations designed to apply a uniform set of methods for reviewing the quality medical care and create new procedures to deal with deficiencies.
- The federal Physician Payment Review Commission, an independent advisory body within the Department of Health and Human Services responsible for recommending changes in the ways Medicare pays doctors, would be empowered to study and test possible ways of reforming the current medical malpractice system and recommend changes to Congress.
- The federal government would increase spending on programs to provide medical services in underserved areas, to promote wellness and healthy habits among the population, and to conduct more research on treating long-term illnesses and disabilities.

PROBLEMS WITH THE COMMISSION'S INSURANCE RECOMMENDATIONS

The most serious and crippling problem in the Commission's majority report is its enormous cost. The report estimates that if all the proposals were put into effect immediately, federal government spending would need to increase next year by $24.3 billion for expanding coverage to the uninsured, $42.8 for establishing the new long-term care entitlement, and $2.6 billion for restructuring Medicare to comply with the new universal mandated minimum health benefits package. The net total cost is a staggering $68.8 billion. To put this sum in perspective, it:

♦ Is larger than the combined 1990 budgets of the Departments of Commerce, Education, Interior, Justice, Labor, and State;

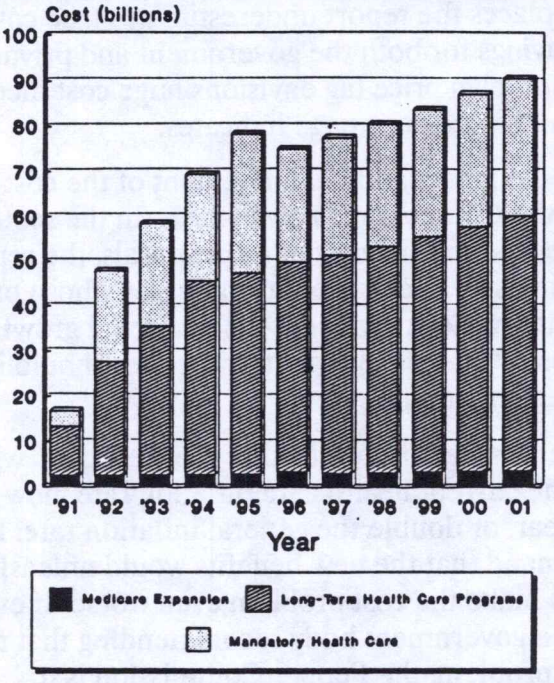
♦ Equals three times the 1990 budget for the Department of Housing and Urban Development;

♦ Is almost two-thirds of the amount the federal government will spend in 1990 on Medicare;

♦ Represents a 5.3 percent increase in the entire federal budget.

Besides this enormous direct cost to the taxpayers, there would be additional indirect costs to Americans. For instance, the report estimates that its proposals would cost American industry $14.7 billion per year to comply with its new requirements.

PROJECTED COSTS OF PEPPER COMMISSION REPORT
New Federal Spending In Constant 1990 Dollars Using Optimistic Assumptions



Notes:
This graph is based on the assumption that the Commission's recommendations are put into effect starting in 1991, and phased in according to the Commission's proposed schedule.
The Commission tacitly admits that the costs of its recommmendations will escalate in future years at rates of "at least 8 percent to 9 percent annually." Taking the lowest estimate (8 percent), and discounting for an assumed constant general inflation rate of 4 percent, yields a projected 4 percent rate of real spending growth.
The 4 percent rate of real spending growth is applied here to years beyond those for which the Commission provided estimates. Thus, this growth rate assumption is applied to: years 1997 and beyond for the mandatory health insurance provisions; years 1995 and beyond for the long-term care provisions; and years 1992 and beyond for the Medicare expansion provisions.
The decrease in total spending in 1996 is attributable to the projected elimination of tax credits to small businesses for health insurance, effective that year.

This estimate of the business costs, however, hides huge disparities in the burden on individual businesses. For example, the Commission calculates that while businesses now providing their workers with insurance (generally larger firms) would face total new costs of $17.4 billion, these costs would be offset by projected savings of $30.2 billion. The savings would come mainly from dropping coverage for dependents of their workers who would be covered by other employers and from reductions in the amounts billed by providers to better insured patients to cover losses incurred in treating uninsured patients or ones whose insurance pays lower reimbursement rates. These larger firms thus would enjoy total net savings of $12.8 billion. At the same time, businesses not currently providing insurance (generally smaller firms) would face total new costs of $36.4 billion, offset by projected savings of just $8.9 billion, for a total net new cost of $27.5 billion.

Greatly Understated Estimates. Even these cost estimates probably are greatly understated. Some members of the Commission itself argue that in a number of places the report underestimates true costs and overestimates potential savings for both the government and private sector. And even the Commission's own price tag envisions huge cost increases in future years, as the chart on the previous page indicates.

Perhaps the most damning indictment of the cost of the recommendations is found in the Commission's own words. In the section describing possible tax increases to fund the cost of its proposals, the report recommends that Congress choose a package of tax increases whose projected revenues will grow at a rate sufficient to meet the projected growth in spending. "To cover program costs," states the report, "revenues should increase by at least 8 percent to 9 percent annually."[3]

This statement tacitly admits that the "reforms" will do absolutely nothing to reduce the current health care inflation rate, now running at 8 percent to 9 percent a year, or double the general inflation rate. Indeed, given the increased demand that the new benefits would unleash, the most likely effect would be to make the cost problem even worse. If ever there were a classic example of a government body recommending that the nation blindly throw money at a problem, the Pepper Commission is it.

The Damaging Economic Effects

Obscured perhaps by the direct costs of the Commission's proposals are numerous threats to the U.S. economy and individual citizens. Of particular concern is the proposed mandate of employer-provided insurance. This would constitute a heavy tax on jobs. Whether employers complied with the mandate by spending more on private insurance or by paying a 7 percent payroll tax to cover their workers under the new public program, the effect

3 *Ibid.*, Chapter 5, "Revenues to Finance Commission Recommendations," p. 137.

would be the same. As with any tax, the more the government taxes something, the more it discourages it. Taxing employment means fewer jobs.

The Commission generally pretends that it is employers who would bear the cost of the new spending or payroll taxes required to comply with the mandate. But it is forced in its report to admit that these costs really fall on workers, weakly conceding: "Economists typically assume that required employer expenditures are borne by workers, in reduced wages."[4] Indeed, the report explicitly admits that these costs will fall hardest on low-wage workers, the very population that is now most likely to lack health insurance. In the Commission's own words, "Wage reductions, however, are not possible for workers at or near the minimum wage. For these workers, the cost would be reduced employment. These reductions could come in layoffs, slower rates of employment growth or failure to replace workers who leave their jobs."[5]

Huge Job Loss. The report estimates that the unemployment resulting from its recommendations would be between 25,000 and 50,000 jobs. But it then dismisses it as "a number that is small enough to be offset by job creation through the normal workings of the economy." However, Commission member and labor economist John F. Cogan, now a Hoover Institution Senior Fellow and formerly Deputy Director of the Office of Management and Budget (OMB), sharply disagrees. The only economist to serve on the Commission, Cogan projects the likely job losses to be in the range 500,000 to 1.4 million.[6] Neither projection, however, considers an economy in recession, with a slow, or even negative rate of job growth. Also left unstated is the fact that newly unemployed individuals and their dependents would increase the burden on other public assistance programs, adding to the indirect cost of the Commission's proposals.

Higher-wage workers would not tend to face job cuts, but employers would tend to compensate for any increased employment cost imposed by the new mandate by adjusting salaries or other fringe benefits. The result: reduced disposable income for these families and hence cutbacks in non-health spending. Employers might also recoup part of the extra costs by raising the prices they charge for their products, making U.S. goods less competitive here and abroad. Furthermore, as the cost of these new taxes and mandates escalate in the future faster than wages and general inflation, as the Commission implicitly admits they will, all of the adverse economic effects would grow.

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4 *Ibid.*, Chapter 2, "Blueprint for Health Care Reform," p. 67.

5 *Loc. cit.*

6 *Ibid.*, pp. 167-168.

WHY THE PROPOSALS WOULD BE POLITICALLY UNSTABLE

Even if Congress were to enact the Commission's recommendations, they would not be a lasting reform because the programs would soon founder amid political and economic turmoil – much as the 1988 catastrophic health care legislation began to unravel before it even took effect. There would be, for example, enormous constituency pressure on Congress to add more and more services under the mandated minimum benefit package, and reduce its cost-sharing requirements on beneficiaries. This would come from consumers wishing more "free" or "lower cost" services. But it would also come from providers initially excluded from the system (for example, chiropractors or optometrists). There can be little doubt that Congress would bow to this pressure. State legislators already have done so, enacting over 800 laws in the past fifteen years requiring insurers to cover specific providers or services – even when consumers expressed little or no interest in the benefits. The political and economic problem of state insurance mandates, which artificially increase the cost of insurance, simply would be transferred to the federal level.

Another source of instability is the assumption that co-payments and other forms of cost sharing would be raised to keep pace with general inflation. Indeed the Commission fails to recommend such a basic inflation adjustment for future years. If the proposed coinsurance rates remain constant over time, their real values will erode and their effectiveness in deterring wasteful consumption will gradually diminish. In the case of beneficiary cost sharing, Commissioner Cogan points to the Medicare outpatient deductible as an example of how political pressure generated by beneficiaries would produce results contrary to good economic and health policy.[7] In the quarter-century history of Medicare, Congress has increased that deductible only twice, from the original $50 to the current $75. Had the deductible simply increased according to the general inflation rate, needed for its effects on consumer behavior to remain constant, it would today be $203.

Web of Regulation. The political and economic instability of the Commission's proposed scheme would soon manifest itself in other ways as well. As insurance costs escalated, Congress would come under increasing pressure from business and taxpayers to regulate health care providers. The result would be a growing web of government regulations, restrictions, and price fixing, leading inevitably to even more distortions in the system. Ultimately, Congress would be faced with the option of either deregulating the system and handing the resources and decision-making power back to consumers and providers, or, more likely, following regulatory logic to its natural conclusion by creating a fully nationalized system.

It is actually quite likely that the greatest pressure for a fully nationalized system would come from employers. By proposing a universal system of man-

7 *Ibid.*, p. 169.

datory insurance, with government specified benefits and narrow limits on the prices insurers can charge, the Commission effectively has called for a national health system paid for and administered by thousands of employers and insurance companies. Most companies in America are not in the health care business, and it would not be long before they tried to shed the burden by pressing for the government to take over the national system.

A government monopoly, of course, would achieve some initial savings, but over time it would become as unresponsive and inefficient as any other monopoly. This pattern can be seen readily from the experience of other countries with national health systems. In common with such countries as Britain and Canada, the U.S. would face large problems in trying to control the actions of both providers and consumers. Consumers would demand more and more services; providers would resist cost controls. Eventually, as in all nationalized systems, the government would only be able to restrain escalating costs by imposing a cap on total health care spending, with the inevitable results of rationing and waiting lists, to adjust the disparity between unrestrained demand and finite resources. In Canada, for instance, patients can expect to wait four to seven months for heart surgery, two to five months for disc surgery, two to seven months for cataract removal, and up to a year for hemorrhoid surgery or hernia repair.[8]

The Alternative Approach

The alternative to this bleak prospect is to introduce strong market mechanisms to America's health care system. Rather than trying to assist the poorer or less healthy members of society by artificially lowering prices, they could be assisted far more efficiently by direct subsidies that sufficiently increased their purchasing power and thus allowed them to obtain the services they needed. Specifically, Congress should:

- Provide all Americans with a basic tax credit for all of their health expenses , both for out-of-pocket medical care and health insurance premiums;
- Increase the percentage of the tax credit for taxpayers whose total health expenses exceeded specified percentages of total family income. This would create a sliding scale of tax relief with the most money going to those who had larger health expenses relative to income;
- Require employers to allow workers to take the money now spent on their health insurance in cash so they could use it to buy medical care and insurance of their own choice elsewhere and pocket any savings;

8 Steven Globerman and Lorna Hoye, "Waiting Your Turn: Hospital Waiting Lists in Canada," *Fraser Forum*, The Fraser Institute, Vancouver, Canada, May 1990, pp. 16-21.

- ♦ Reform current public assistance programs to provide low-income Americans with vouchers based on income to use in purchasing medical care and health insurance;
- ♦ Require all heads of households to purchase basic catastrophic health insurance for themselves and their families;
- ♦ Fund these changes by eliminating the current tax exclusion for employer-provided health insurance, thus making them budget neutral;[9]

With this system of tax credits, working Americans would be able to buy for themselves the health insurance and medical care they needed for themselves and their families. Furthermore, by putting the dollars and decision-making power back in the hands of consumers, this strategy would provide new incentives for Americans to seek the best value in medical care and health insurance. In this way, consumers would exert pressure on providers and insurers to become innovative and efficient. All parties concerned, consumers providers and insurers, would be tangibly and directly rewarded for any steps they took to curb escalating health care spending and reduce or eliminate administrative costs and wasteful or marginally useful purchases.

WRONG GOALS IN LONG-TERM CARE

The Commission's recommendations for helping Americans who lack health insurance are a case of pursuing the right goal with the wrong methods. Its recommendations for reforming the financing of long-term care, however, are a case of pursuing the wrong goal entirely.

For many Americans, the actual or potential need for costly long-term care for themselves or relatives is an important and pressing financial question. Naturally, one of the places they look to for solutions is Congress. Lawmakers can and should take some significant steps to improve the financing of long-term care. But the Pepper Commission does not provide a blueprint for anything other than a policy disaster.

Before enacting any long-term care legislation, Congress needs to remember two very important points:

1) **The federal and state governments already provide some $25 billion in long-term care assistance, chiefly through the Medicaid program.** This assistance is targeted to those who need it the most: the poor; individuals who become poor as a result of long-term care expenses; and the healthy spouses of nursing home patients who, in the absence of public assistance, soon would become impoverished.

9 For a more detailed explanation of these and related proposals, see Butler and Haislmaier, *op. cit.*, and Butler, *op. cit.*

2) **While reforms in Medicaid are needed so that existing funds can be used more efficiently, those most worried about long-term care costs are not the poor.** Rather, they are older workers and retirees with comfortable levels of assets and income, who are ineligible for Medicaid. These Americans correctly fear that the potential costs of long-term care could completely consume the savings and assets they have carefully accumulated over a lifetime, leaving nothing for their heirs. While it is easy to sympathize with these fears, the fact is that long-term care for middle-income and upper-income Americans does not concern access to needed medical care, but questions of asset protection and estate planning.

With workers already funding $356 billion a year in subsidies to the elderly through Social Security and Medicare, to call for imposing on them another $42.8 billion in taxes simply to protect the private estates of affluent senior citizens is irresponsible. Not one cent of the new spending proposed by the Pepper Commission would go to help impoverished senior citizens obtain care they currently need but is not already provided for them by Medicaid.

Furthermore, from an insurance perspective, even the very structure of the Commission's proposed long-term care program is backward. The program would provide the most generous benefits to those facing the least risk. These are the relative majority of disabled elderly Americans who incur short nursing home stays or need only limited spells of home care assistance. The much smaller number who incur long stays in a nursing home or need more extensive home care would still face large out-of-pocket bills. Such an inverted scheme might be attractive to Congressmen seeking to buy the greatest number of votes from their elderly constituents, but it cannot be called insurance and it is no solution to the long-term care problem.

Moreover, the likelihood of the costs of such a program ballooning completely out of control in future years is just as acute as in the medical care system envisioned by the Pepper Commission. Warns Commissioner Cogan in his dissent to the report:

> During the last 15 years, numerous proposals have been brought before the Congress to provide long-term care assistance for the elderly. Each proposal has failed enactment. The principal barrier has been long-term care's exorbitant expense and the well-recognized fact that we have no known method of controlling its explosive cost growth. Nothing in the majority's recommended plan alleviates these concerns. While I have great respect for the Commission's staff, I have no confidence that the estimated cost of $42.8 billion will prove accurate. More likely, the estimate will prove to

be only a fraction of the recommendation's eventual cost.[10]

THE ALTERNATIVE STRATEGY

Congress's role should not be to create an enormous new federal entitlement program that imposes additional, heavy taxes on working Americans simply to further subsidize affluent retirees. Rather, lawmakers should stick to the more appropriate tasks of improving the delivery of long-term care services to the poor – those who legitimately need government help – and encouraging middle-income Americans to use private insurance to protect their assets from nursing home costs – precisely the same prudent actions they take to protect themselves from other financial catastrophes.

Specifically, Congress should:[11]

- Restructure the public assistance for long-term care, now provided through Medicaid, to create a more responsive program for meeting the needs of the elderly poor;
- Encourage working Americans and their spouses, through tax incentives, to buy long-term care insurance while they are younger and the premiums are low, to protect themselves when they retire;
- Provide tax relief to help working families willing to shoulder the cost of providing non-institutional care to their elderly relatives;
- Change existing tax policies and regulations to enable today's middle-income and upper-income retirees to obtain more affordable long-term care insurance, and remove penalties to enable them to use their existing financial assets and resources, such as life insurance and Individual Retirement Accounts, to pay for long-term care services;

Such a strategy constitutes a much fairer, compassionate and efficient approach to meeting the needs of America's present and future retirees for long-term care, than that proposed by the Commission.

CONCLUSION

Some 31 million Americans lack health insurance today for at least part of any year. The reason: they have been priced out of the market by escalating health care costs and tax policy that discriminates against them. A majority of the Pepper Commission proposes that Congress respond to this problem by throwing more money at it. While such an approach certainly would result in some improvement in coverage, the costs would be unacceptably high. Those

10 Pepper Commission Final Report, *op. cit.*, p. 172.

11 For a more detailed explanation of these and related proposals, see Edmund F. Haislmaier, "Making Long-Term Health Care More Affordable," Heritage Foundation *Backgrounder* No. 755, February 23, 1990.

costs would come in the form of new federal spending, higher taxes, reduced employment and diminished disposable income for Americans.

Basic Structural Reform Needed. Furthermore, even those costs will escalate in future years unless Congress reforms the basic underlying incentive structure that govern the decisions of health care consumers, providers and insurers. The present employer-provided insurance system, and particularly the health care tax policies and regulations that support it, have created a system in which consumers are encouraged to over-consume and providers to over-price and over-prescribe. Neither consumers nor providers are directly and tangibly rewarded for economy or efficiency. Prudent consumers thus are effectively prevented from pocketing any savings they achieve on their health care. And efficient providers and insurers who offer good value – that is, quality services at reasonable prices – rarely can attract more customers.

Until this situation is reversed, health care costs will continue to escalate and even more Americans will join the ranks of the uninsured. All the Pepper Commission proposes is to pour gasoline on the inflation fire by legislating access to health and then passing the tab to business and the taxpayer. If Congress adopts the Pepper Commission's "solution" only one thing will change. The escalating costs will be expressed not in terms of more uninsured Americans, but rather in terms of higher taxes, fewer jobs and declining productivity and purchasing power. Such a result is hardly a solution.

Needed instead, is for Congress to enact reforms which create a consumer-oriented, market-based health care system. The keys to such reforms are that:

1) **Consumers be given control** over the money spent on their health care and the power to decide how best to spend it;

2) **All Americans receive,** through the tax code, an equal incentive to purchase needed medical care and health insurance;

3) **The tax code and public programs be further reformed** to provide direct subsidies to Americans with low incomes or high medical costs, sufficient to increase their purchasing power in the medical marketplace and thus allow them to buy the care and insurance they need.

These reforms would create powerful new incentives for consumers, providers, and insurers to seek or provide the best value in health care – quality services at reasonable prices. Furthermore, rather than the system being distorted by the unintended consequences of government attempts to artificially lower health care costs for the needy, a restructured subsidy system would directly give to disadvantaged Americans the extra purchasing power they need to buy into the reformed and improved medical market.

While the Pepper Commission proposes the wrong means to achieve the worthy goal of expanding access to health insurance and medical care for the uninsured, it seeks to achieve the wrong goal entirely in long-term care policy. The goal of reform in long-term care financing should not be to find ways for the government to protect the estates of affluent retirees. Rather, the goal should be to clear away obstacles in the tax code and government

regulations that hamper efforts by Americans to use private means to protect their private assets. Even more important, Congress should eliminate policies that encourage Americans to ignore their own potential need for long-term care until it is too late to do anything but rely on government assistance.

Removing Tax Biases. Equalizing the tax treatment of all medical care and health insurance expenses, including those for long-term care as well as acute care, would be a major step in the right direction. With existing biases removed from the tax code, Americans quickly would see that the best value for their health care dollars is found in purchasing insurance for unlikely but expensive events, such as catastrophic acute or long-term care, and not in covering routine medical treatments. To its credit, the Commission does propose a small step in this direction, arguing that employer provided long-term care insurance should receive the same tax treatment as employer-provided acute-care insurance. But this is far from enough, and in the context of the Commission's other recommendations would probably have little, if any, effect.

Not only should Congress make this reform part of an overall restructuring of health care tax policy, but it should also remove barriers to Americans using their existing financial assets, such as life insurance and Individual Retirement Accounts (IRAs), to pay for long-term care insurance and services.

Unfortunately, the Pepper Commission failed to provide the workable solution to America's health care problems that many members of Congress had hoped for. Those problems are too important to leave unattended. Congress should put the Commission's report aside and move on with the difficult task of developing better access to affordable health care for all Americans.

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Pepper Commission

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Working Meeting Number Thirteen:
Initial Agreement on Structure

December 15, 1989

Purpose of the Meeting

The purpose of this meeting is to explore the potential for agreement on the basic elements of our proposed recommendations for expanded access to coverage for health care and long term care. The Chairman will introduce a proposal outline to focus the discussion.

You or your staff have been briefed on the proposal. Its key features will provide the agenda for discussion (see attached). The agenda will not include all issues the proposal or the Commission must ultimately address. Rather it will deal with "threshold issues"--decisions that determine the basic direction our recommendations will take.

Other issues, to be addressed at January meetings, include:

- o benefits to be included in proposed coverage expansion
- o financing mechanisms
- o federal-state roles in financing and administration
- o quality assurance (including practice guidelines and malpractice reform)
- o delivery interventions for the underserved
- o changes in health care benefits for the elderly.

If there are critical issues you wish to raise on December 15 that are not on the agenda, please let the staff or the Chairman know as soon as possible.

2

Working Meeting Number 13
December 15, 1989

Agenda

Following a walk-through of the Chairman's proposal outline, a series of questions will be used to order our discussion of the proposal's key elements. Members should be prepared to indicate whether they agree with the plan's elements, would like to revise these elements, or have an alternative to propose.

9:00 - 9:15 Chairman's Opening Remarks

9:15 - 9:45 Staff Walk-through of Chairman's Proposal Outline

9:45 - 11:00 Employer/Public System

Should public policy expand health care coverage through an employer/public system? How?

11:00 - 12:00 Private Health Insurance

Should public policy promote change in insurance practices to assure availability of coverage to all at affordable rates, regardless of health status?

To what extent should coverage through a public program be allowed or promoted as an alternative to private insurance?

12:00 - 1:00 LUNCH

1:00 - 2:15 Health Care Cost Containment

What measures should be used to contain costs?

2:15 - 3:45 Social Insurance in Long-term Care

What is the role of social insurance, relative to private insurance or means-tested protection? For some or all services?

3:45 - 4:00 Next steps

Direction to staff
Agenda for future meetings

OVERVIEW OF HEALTH AND LONG-TERM CARE PLANS

HEALTH PLAN

The goal of assuring access to coverage for all Americans is achieved through a combination of (1) requiring employers to offer insurance to their employers or to pay a tax, and (2) establishing a public plan that can provide coverage for all those without private insurance. The public plan would be federally financed and run, replacing Medicaid.

To assure the availability of decent, affordable coverage to employers, improvements would be made to the private insurance market.

Costs would be contained by building on the provider payment principles now in place or soon to be in place in Medicare, and allowing development of managed care initiatives.

LONG-TERM CARE

Regardless of age or income, all Americans are insured through a government program for home care and short stays in a nursing home. To qualify for benefits, persons would have to be severely disabled.

For nursing home stays longer than those covered under this plan, persons would rely on private insurance, on savings, or on Medicaid, which would continue to be means-tested.

Federal and state governments would share financing, and states would administer the program under federal guidelines.

12/13/89

HEALTH PLAN

WHO'S COVERED AND HOW

- Employers must either provide insurance to cover specified services for employees, or pay a tax.
- Everyone not covered through an employer plan can get insurance through a federal program, or, if they wish, can purchase private insurance.

PRIVATE INSURANCE PROVISIONS

Private insurance market is improved so that no one is denied coverage, at reasonable rates, because of health status.

COVERAGE OF LOW-INCOME PEOPLE

All low-income people, including current Medicaid acute care recipients, would be covered under the new plan for the specified benefits.

FINANCIAL OBLIGATIONS

Employers

- If employer chooses to buy insurance, it pays at least a specific share (for example, 80%) of premium for full-time employees (and a proportional contribution for part-time employees to participate in public plan).
- If employer chooses not to buy insurance, it pays a tax.
- Small business subsidy -- Help for obligations for small, new and heavily burdened businesses.

Individuals

- Pay deductibles, coinsurance and a specified portion of premium (for example, 20%), within appropriate out-of-pocket limits.
- Subsidy for low income people--No payments for low income persons, with sliding scale payment above the chosen cut-off point.

Federal Government

Funds needed to subsidize low-income people, subsidize small businesses, and cover public plan costs that exceed employer tax revenues and individual payments.

State Government

- o No obligations for services covered by new federal plan (that is, new federal plan replaces current Medicaid obligations).
- o Continued responsibility, at their option, for optional services now offered under Medicaid, but not included in new plan.

BENEFITS

Benefits package including at least medically necessary hospital and physician services, primary and preventive care. Benefits are subject to cost sharing, up to a maximum.

COST CONTAINMENT

- o Public plan sets provider payment rates in conjunction with (and according to rules of) Medicare program.
- o Private insurers have the option to use publicly determined rates (which providers must accept as a condition for participation in Medicare and new public program).
- o Opportunity for private insurers' development of managed care.
- o Improvement in the private insurance market that directs competition toward efficient delivery.
- o Cost sharing

QUALITY ASSURANCE[1]

- o Technology assessment and practice guidelines which are developed, in part, with the help of a newly created health outcomes data base.
- o A system that builds on existing mechanisms for quality assurance.
- o Malpractice reform

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[1] CAO is preparing a report for the Commission on approaches to quality assurance and the Commission has contracted with Professor Paul Weiler of Harvard Law School for a report on options for malpractice reform.

LONG-TERM CARE SOCIAL INSURANCE FOR THE SEVERELY IMPAIRED

Create a new limited long-term care social insurance program for the severely impaired.

ELIGIBILITY

- Persons assessed as "severely impaired"
- All ages

BENEFITS

Case manager decides actual mix of services.

Home and Community-Based Care (HCBC):

- Includes skilled nursing, personal care services, homemaker services, adult day care, respite care.
- Amount of services dependent upon level of disability up to a maximum ceiling (for example, 25 hours/week).
- Family support included in the case manager's decision to allocate services.

Nursing Home Care:

- "Front-end" coverage (for a specified period per stay; for example, 6 months).
- Limit on lifetime use--perhaps 3 episodes or 18 months.

COST SHARING

- Coinsurance for HCBC and nursing home care benefits
- Subsidize coinsurance for low-income persons

COST CONTROLS

- Government approval of provider rates
- Certified case manager authorizes services, within a fixed budget.
- Cost sharing

ADMINISTRATION

- Federal-state financing
- Federal administrative responsibilities: Set eligibility standards, certify assessment agencies and oversee provider payments.
- State responsibilities: Design and implement delivery structure, certify providers and oversee case management.

OTHER LONG-TERM CARE

- Encourage private insurance for lengthy nursing home stays:
  - Tax clarification
  - Government standards and oversight
  - Medicaid waivers to promote private insurance policies
- Retain Medicaid program for persons who--
  - stay in nursing homes over 6 months, or
  - need care but do not satisfy the social insurance program's eligibility requirements (not "severely impaired").
- Improve Medicaid program:
  - Raise asset protection levels for all nursing home residents.
  - Raise personal needs allowance.
  - Assure no deterioration of care for persons exhausting period of nursing home care under social insurance plan.