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MEMO



To: HEALTH CARE POLICY MAKERS

From: DAVID M. MASON, *Director of Executive Branch Liaison*

Date: FEBRUARY 9, 1992

Subject: THE BUSH HEALTH PLAN, CONGRESS' GREAT DEAL and
TALKING POINTS ON THE HEALTH CARE DEBATE

President Bush's Health Care Plan takes some steps toward market-oriented reform, but doesn't go far enough, writes Stuart Butler, Heritage's Director of Domestic Policy Studies, in **What's Right and Wrong with Bush's Health Plan**, which is enclosed along with two other Heritage papers on health care.

If Congress is looking for a proven model of a competitive health system, it need look no further than its own health plan - the same one that covers all federal employees. The "FEHB" gives consumers a broad choice of plans, controls costs, and keeps administrative overhead down. **Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program**, by Heritage Deputy Director of Domestic Policy Studies, Bob Moffit, asks: if its good enough for Congress, why isn't a consumer-based health plan good enough for the rest of America?

Finally, if you're looking for a guidebook to the range of debate on health care, look no further than **A Policy Maker's Guide to the Health Care Crisis, Part 1: The Debate Over Reform**. These Heritage Talking Points, also written by Stuart Butler, provide a simple but comprehensive overview of the current debate over health reform, including descriptions of the major alternative plans.

I am sure that you will find these Heritage publications on health care useful. We will continue a heavy publication schedule on the health care debate over the next several months. If you are interested in Heritage's health care activities or our own reform plan, please contact me. If you have colleagues who would also be interested in our health research, please have them return the enclosed form.

INTEREST SURVEY - HEALTH CARE ISSUES

If you are interested in receiving Heritage Health Care publications, or know colleagues who would be, please fill out and return this form.

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Executive Memorandum

The Heritage Foundation

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RUSH!

2/7/92 Number 321

WHAT'S RIGHT AND WRONG WITH BUSH'S HEALTH PLAN

George Bush has taken the bold first step toward solving the underlying problem of America's health care system. He has offered a plan that would make it much easier for uninsured Americans to obtain coverage. This is a very welcome proposal. But it does not go nearly far enough to deal with all the health insurance problems facing Americans. Thus unless Bush takes his reform package to its logical conclusion, he will not deal fully with the health care crisis. By avoiding a more comprehensive reform, moreover, he may actually increase the political obstacles to enactment of his limited plan.

According to surveys, the biggest health care concern facing most Americans is that if they change jobs, or lose them, they face the loss of health benefits—and potential financial catastrophe. Of concern too is that millions of other Americans have no health coverage at all, because they lack a company plan. In addition, employers and their workers, who pay part of their company coverage, worry about the surging cost of health insurance.

These problems arise because tax benefits are available in most instances only for company-sponsored health plans. This has led to health insurance—unlike life insurance, auto insurance or homeowners insurance—being based on the place of work. Thus if the worker leaves his or her company, the worker and his family can suddenly lose coverage. And workers in companies that do not provide coverage typically do not have insurance. If they then buy their own plans, they must pay for them in after-tax dollars. By contrast, the favorable tax treatment of, say, a whole life insurance policy has nothing to do with the place of work, and the breadwinner in a family does not lose his life insurance when he changes jobs.

Moreover, because most health coverage is “paid for” by employers, workers tend to have the illusion that coverage is largely free. This leads them not to question the cost of health services or to seek the best value for money in a plan. This in turn encourages health care providers to raise prices rapidly and makes it difficult for firms to control costs without incurring employee anger.

Health Voucher. The Bush plan would solve at least some of these problems. It introduces a refundable credit, which in effect is a health voucher, for lower-income Americans. With the credit, these Americans can purchase a health care plan irrespective of their place of employment or even if they are employed. The Bush plan also makes it much easier for middle-income families to deduct from taxable income the cost of health plans they purchase. This makes the tax treatment of these individually purchased plans much like that of company-sponsored plans.

The Bush proposal thus ends the tax benefit monopoly of only company-sponsored health plans. Under the Bush plan, Americans who work for small firms without plans, or who are casual or seasonal workers, or who often change their jobs, would have tax breaks to pay for health coverage that they would take with them from job to job, just as they do with a typical life insurance plan. Since these Americans would pay the premium themselves, albeit with tax help from the government, they would also have the financial incentive to seek the best value for money.

While some of the regulatory changes in the Bush proposal raise concerns, one helpful step makes it easier for insurance plans to be offered to groups of individuals. Thus, groups of small employers, or organizations other

than employers—perhaps unions, churches, or farm bureaus—would be able to develop and market competitive health insurance plans for families. Union-sponsored plans already are a major feature of the health system for federal employees. The Mail Handlers plan, for instance, has about 500,000 enrollees, over 90 percent of whom are not even members of the union. Bush's insurance reform permits such union plans to be offered nationwide.

Where the Bush proposal falls short technically and politically is in the way it would pay for the new credits and deductions, estimated to cost the Treasury \$100 billion in lost revenue over five years.

Tax Overhaul. The best way to finance the plan would be through an overhaul of the entire tax treatment of health spending; this could be "budget neutral," meaning no revenue would be lost to the Treasury. An example of this approach is The Heritage Foundation's Consumer Choice Health Plan. It would phase out the tax-free status of company-based health plans, replacing it dollar for dollar with a tax credit for all families, not just the poor. Workers with employer plans today could take the cash value of their plans and buy alternative coverages, pocketing any savings.

Calculations for The Heritage Foundation conducted by the Washington D.C.-based econometric firm of Lewin/ICF, recognized experts in assessing the costs and impact of health care, indicate that such a changeover in tax breaks would leave most middle-income families slightly better off, with lower taxes and lower out-of-pocket health costs. More important, the Heritage plan offers two distinct advantages. First, workers currently insured by their company would have a financial incentive to seek a better value plan from another source; the competitive dynamics created by this would tend to reduce total health costs. The Bush plan, by not addressing the tax treatment of company-sponsored plans, does nothing to encourage cost control in these plans. Second, by allowing workers to choose plans unconnected to their place of work, the Heritage reform would make it easier for all workers to obtain "portable" health plans. The Bush proposal does not include such a comprehensive tax reform.

Thus Bush Administration is, in fact, very vague about how the new tax benefits will be financed. It appears part of the cost will be paid for by adjusting the federal government's support for Medicaid. A Medicaid formula change makes sense, since the new federal credit means the states would enjoy billions of dollars of savings in Medicaid and other programs for the uninsured. The Bush proposal also would encourage greater use of cost-saving managed care in Medicaid, another welcome step.

It is unclear how the rest of the cost will be financed. One proposal floated earlier—but not included in the plan—was to place tighter price controls on Medicare fees. This would make no sense, from either a policy or political point of view. Years of price controls already have distorted Medicare treatment practices and encouraged doctors treating the elderly to "shift" those costs not fully reimbursed by Medicare onto the bills of other patients. Tighter price controls simply would compound this problem. From the political perspective, elderly organizations likely would charge that the Bush plan is a cut in Medicare. While this claim would be an exaggeration, it could trigger powerful opposition to the whole plan from elderly interests.

Major Improvement. For all its shortcomings, however, the Bush proposal is a major improvement over almost all the other health care proposals under consideration in Washington. Unlike proposals to establish a nationalized system in the United States, like that of Canada, the Bush plan would not mean systematic rationing and exploding government health budgets. And unlike proposals (some called "play or pay") to make employers offer insurance or pay a tax to cover workers in a public program, it would not raise labor costs and cast tens of millions of Americans into a mega-Medicaid program. Now that he has taken his first bold step, Bush vigorously should keep moving America toward a universal health system based on consumer choice and competitive private markets—the same dynamics that have been the keys to efficiency and consumer satisfaction in every other part of the U.S. economy.

Stuart M. Butler, Ph.D.
Director of Domestic and Economic Policy Studies

For further information:

Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992.

February 6, 1992

CONSUMER CHOICE IN HEALTH: LEARNING FROM THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

INTRODUCTION

In the debate over national health care reform, there is good news and bad news.

The good news is that Congress actually has discovered the answer to America's health care problem, and the answer is a system that already exists. This system gives consumers wide choice of health plans and "user friendly" advice on how to choose among rival plans. It promotes intense competition among health insurance carriers. It controls costs. It incorporates excellent benefits. And those who are enrolled in it are pleased with the system.

The bad news is that Congress has been keeping this system exclusively for itself and federal workers while considering ways to impose vastly inferior systems on almost all other Americans. What would be fair is for Congress to allow all Americans to have a version of what lawmakers and federal workers reserve for themselves.

Anxious Workers. Surveys show that most Americans are anxious about their job-related health benefits. Many workers worry that if they are laid off, they will lose their current health benefits and may not qualify for coverage at a new job because of their medical condition. Others have no coverage at all, because their company does not offer it, and these workers must try to pay for their own care or insurance without any help from the government.

Problems like these do not worry the President, members of Congress, cabinet secretaries, congressional staff, and the millions of federal employees, retirees,

and dependents who enjoy a system known as the Federal Employee Health Benefits Program (FEHBP).

Consumer Choice Showcase. Like any government program, the FEHBP is far from perfect. Yet it is an excellent showcase of how consumer choice works in health care, and how a system for all Americans based on choice, such as the plan proposed by The Heritage Foundation, would work in practice.¹

Under the FEHBP, some nine million Americans of widely differing income levels and backgrounds, from blue collar messengers on Capitol Hill to the President and each member of the President's cabinet, each year can pick and choose from a wide range of health care plans. Unlike most Americans these congressional and federal employees, as well as retired federal workers, enjoy the unique opportunity to decide what combination of services and price is best for themselves and their families.

Throughout the United States, these fortunate Americans can choose between over 400 health care plans, typically with two dozen choices available in any particular city or county. These range from traditional insurance plans, like Blue Cross and Blue Shield, to a total of 310 Health Maintenance Organizations (HMOs), including such giants as Kaiser Permanente, to union-sponsored health care plans, such as those offered by the huge American Postal Workers Union or the smaller National Treasury Employees Union.

This system based on consumer choice and competing providers works smoothly and is popular with lawmakers and civil servants alike. This is why few ordinary Americans ever hear their senator or congressman complain about their health benefits.

Among the key features of the FEHBP:

X The FEHBP makes it easy for consumers to choose.

Every fall, federal employees receive a simple form listing the plans available in their area. They check off the plan they want. They cannot be turned down by the plan or be required to pay a higher premium. Consumer organizations and the local press give employees the information they need to make informed decisions.

X The FEHBP gives help to pay for coverage.

In making a selection, the employee is quoted a premium price. However, the federal government makes a contribution to the plan, according to a formula and with a maximum dollar limit.

¹ See Stuart M. Butler and Edmund F. Haislmaier, eds. *A National Health System for America* (Washington, D.C.: The Heritage Foundation 1989); Stuart M. Butler, "Using Tax Credits to Create An Affordable Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of The American Medical Association*, Volume 265, May 15, 1991.

X The FEHBP makes it easy for the employee.

The employee's agency, or congressional office, automatically deducts the employee's share of the premium from each paycheck and sends it to a central government fund. A check then is cut by the government for all the employees in a particular plan and sent to that plan.

X The FEHBP encourages health plans sponsored by unions and other employee organizations.

Such plans accounted in 1990 for 35.5 percent of all enrollees. These plans also are available for non-union members. Example: only 5.6 percent of the enrollees in the Mail Handlers Plan are members of the union. By extending their plan to non-union members, the unions can earn a profit. In 1988, for instance, the Mail Handlers Plan made a \$14 million profit, or \$280 for every union member. Some employee organizations, such as the Government Employees Health Association, exist solely for the purpose of sponsoring a plan for themselves,

X The FEHBP promotes managed care.

Managed care plans known as Health Maintenance Organizations (HMOs), which are low-cost plans in which families accept certain limits on their choice of doctor and hospital but normally receive no bills for any treatment, accounted for 26.4 percent of all FEHBP enrollees in 1990. In America as a whole, only 13 percent of Americans are enrolled in HMOs.

X The FEHBP rules are simple.

In a refreshing contrast to most large government programs, FEHBP is relatively free of red tape. The law creating the FEHBP is eight pages long, with sixteen pages of regulations and less than 100 pages of information and instructions. By contrast, the law covering Medicare is 142 pages long, with 400 pages of regulations and almost 11,000 pages of instructions.

X The FEHBP keeps costs down.

The annual rate of increase in costs during 1980-1988 was 12 percent, compared with an average of 14 percent in the private sector—this despite the fact that the FEHBP covers a growing number of retirees, including retirees without Medicare whose health costs have been rising much faster than for younger Americans. Typical plans offered by private firms do not.

What is the secret of FEHBP? It promotes consumer choice and a competitive insurance market. The law governing private sector workers, by contrast, does not.

The tax code affecting the private sector gives tax relief normally only to a plan offered by a company to its employees. If the employee would prefer another, more economical, plan, he or she receives no tax break and thus has no incentive to switch to it. Yet congressmen and other government workers receive the same financial assistance whichever of dozens of plans they choose. This gives them incentive to seek good values for money.

To make matters worse, giving tax relief only for "employer-paid" plans, which in fact becomes part of the worker's compensation package, creates the illusion

among many workers that their health care is free and thus encourages health cost inflation. Federal workers choose plans according to price and quality, and so have strong incentives to economize.

Skeptics of the idea of a consumer-choice universal health system in America often claim that Americans are not capable of choosing their own health coverage. A *New York Times* editorial complains that consumer-choice plans “rely on individuals to buy their own coverage. But the complexity of insurance plans makes comparison shopping virtually impossible by anyone other than an experienced professional.”² The FEHBP system, through over three decades of operation, proves this view to be dead wrong. If low-skilled congressional messengers can choose their plan, so can other Americans.

Congressmen like their system so much that they insist that they be exempted from any new health system that they impose on other Americans. Thus one of the leading “reform” bills in the Senate (S. 1227), sponsored by Majority Leader George Mitchell, the Maine Democrat, like many other health bills, explicitly exempts lawmakers and other federal workers from the coverage, and thus the consequences, of the bill. Rather than keeping their excellent health care system a special privilege for themselves and other federal workers, they should allow other Americans in effect to join the system. What is good enough for Congress should be good enough for the American people.

To open an FEHBP-like system to the uninsured and other working-age Americans, Congress needs to take two basic steps:

First, Congress needs to change the tax treatment of medical benefits to allow tax breaks to Americans wherever they obtain health coverage. This would enable Americans to choose a plan offered by their union, or a managed care plan, or a “high option” insurance plan, wherever they work—a range of choices taken for granted by federal employees and retirees but unavailable to private sector workers.

Second, Congress needs to require working-age Americans not covered by Medicare or Medicaid to purchase at least a basic health plan, and to provide assistance to families who otherwise would be unable to afford care.

The Heritage Foundation’s proposed Consumer Choice Health Plan would accomplish this. Under the Heritage plan, the current tax exclusion for company-based plans would be replaced with a refundable tax credit for a health plan obtained from any licensed source and for out-of-pocket medical expenses. In addition, all heads of households would be required to obtain at least a basic plan. This would give ordinary Americans the same kind of options for health coverage as congressmen and federal workers now enjoy.

2 “Tax Credits for Health: Wrong Rx,” *The New York Times*, December 16, 1991.

Lawmakers assume that the U.S. health system needs major surgery, and Congress now is debating the nature of the required operation. What the patient really needs is a strong dose of consumer choice and competition. Congressmen know this from their personal experience with their own health system based on these powerful dynamics. The way to solve the national health care problem is for Congress to let all Americans have a similar system.

HOW THE FEHBP WORKS

Created in 1959, the Federal Employees Health Benefit Plan is open to all members of Congress and congressional staff, the President, cabinet members, other executive branch appointees, federal judges, judicial staff, and all federal civil service employees and postal service workers. In addition, federal retirees, survivors of deceased federal employees and retirees, and the dependents of active federal employees and retirees are covered. Employees of the District of Columbia also are eligible. Approximately nine million individuals are in the nationwide system. The decision to enroll is up to the employee, and about 85 percent of the active federal workforce is in the program.³ The majority of those not covered by the FEHBP are covered by the plan of a working spouse not in the federal workforce.

In a four-week period each fall known as "open season," federal workers can choose which health care plan will cover them. They can choose any private plan in the system. Most do not change their plan from year to year, but if the worker decides to change plans, he or she has the right to enroll at the same premium as any other plan enrollee, without regard to health condition.

The choice available to federal workers is far wider than for employees of even the largest private corporations. According to economist Walton Francis, author of the *Checkbook Guide to Health Insurance for Federal Employees*, a comprehensive guide to plans published by a Washington, D.C.-based consumer organization, federal workers across the country can choose among over 400 plans.⁴ In the Washington, D.C., area, federal workers can choose from 35 different plans.

The range of plans offered to federal workers is remarkable, as is the range of organizations sponsoring the plans. There are traditional "fee-for-service" insurance plans, offered by such major insurers as Blue Cross and Blue Shield. But the FEHBP law also authorizes employee organizations, like unions, to offer plans.

Union Plans. Union-sponsored plans started to compete successfully with the traditional big insurance companies in the 1970s. Today, fourteen employee-spon-

3 United States Office of Personnel Management, *Study of the Federal Employees Health Benefits Program*. Submitted by Towers, Perrin, Forster & Crosby, Inc., Washington, D.C., April 22, 1988. p. 25. Hereafter cited as *TPF&C Report*.

4 Walton Francis et al. (eds) *Checkbook's Guide To Health Insurance Plans for Federal Employees* (Washington, D.C.: Washington Consumers Checkbook, 1992), p. 4. Hereafter cited as *Checkbook's Guide*.

Table 1 Plans Available to Federal Worker's Families in the Washington, D.C. Area		
Plan	Average Cost to Employee	Maximum Cost to Employee
TRADITIONAL GOVERNMENT-WIDE PLANS		
Blue Cross - High	\$5,630	\$7,050
- Standard	2,260	4,860
- Standard PPO	2,130	4,060
EMPLOYEE AND UNION-SPONSORED PLANS		
Postmasters - High	\$6,110	\$7,410
- Standard	2,700	4,310
National Treasury Employees Union	4,080	6,280
Alliance	3,410	5,730
Foreign Service*	3,070	4,730
Special Agents Mutual Benefit Association - High	2,940	NA**
- PPO*	2,550	NA**
National Association of Letter Carriers	2,870	5,600
Mall Handlers - Standard	2,550	NA**
- High	2,440	NA**
Secret Service*	2,540	4,310
Governmental Employees Hospital Association	2,490	4,210
American Postal Workers Union - Standard	2,310	3,550
- PPO*	1,840	3,200
Beneficial Association of Capital Employees - Standard*	2,160	3,360
- PPO*	1,710	2,610
HEALTH MAINTENANCE ORGANIZATIONS		
Physicians Care	\$3,240	\$3,430
Group Health - High	2,580	3,740
- Standard	1,870	3,520
Lincoln National	2,290	2,630
Prudential	2,210	2,360
Columbia	2,160	2,520
Free State	2,130	2,590
George Washington - High	1,870	NA**
- Standard	1,820	NA**
HealthPlus - Standard	1,710	3,110
- High	1,580	2,150
Aetna Health	1,700	2,430
Potomac Health	1,640	1,820
M.D. IPA	1,580	1,950
Kaiser	1,550	1,930
Care First	1,500	1,790
Note: The Average Cost is the approximate yearly cost to employee, including premium, dues, and unimbursement bills for a typical mix of Hospital, Medical, Drug, and Dental Bills for a family of four. The Maximum Cost is the total out-of-pocket costs including premium, for a family; also known as the catastrophic limit. PPO = Preferred Provider Organization *Plan is only open to specific groups ** The Catastrophic limits of these plans do not include prescription drugs; therefore there is no definite limit. Source: Checkbook's Guide to Health Insurance Plans for Federal Employees, 1992 Edition. Data reprinted with permission.		

sored plans are available to federal workers, including union plans, and several of these plans are available to those who are not regular members of the union. In the latter case, the union or employee organization normally requires outside enrollees to pay modest "associate membership" fees, normally between \$30 and \$35 per year.⁵

The marketing success of these employee organizations has been phenomenal; by 1990 they included almost 36 percent of all FEHBP enrollees. A good example is the Mail Handlers union. According to a 1988 study conducted for the Office of Personnel Management (OPM):

The Mail Handlers Benefit Plan has been so successful that the plan now dwarfs the union that sponsors it. There are approximately 30,000 regular members of the union in the health plan and nearly 500,000 enrollees. With associate membership dues of \$30 per year, the plan generates approximately \$14 million in revenue for the union, or \$280 for every regular dues paying member. A representative of the Mail Handlers Plan advised us during an interview that most of the plan's enrollees are not postal workers; they are civilian employees in various agencies of the Executive Branch.⁶

Another example of a successful employee organization plan is the Government Employees Hospital Association (GEHA). This plan was developed by a group of federal employees not associated directly with any union. In fact, according to a study for OPM, "This organization's sole purpose appears to be the offering of a health insurance plan under FEHBP."⁷ And the "organization" itself simply is the group of employees who have chosen the plan.

Managed Care. Another type of plan growing rapidly among federal employees is managed care. In managed care plans, enrollees accept certain restrictions on their choice of physicians and hospitals in return for lower premiums. The best known form of managed care plan is a Health Maintenance Organization or HMO. The patient in an HMO normally receives no bills for treatment. He or she simply pays a fixed monthly fee for all care.

Table 2 shows the growth in the range of options available nationally to federal workers during the 1970s and 1980s. Per enrollee, the number of choices doubled from roughly a dozen to two dozen plans. Since 1988, the average number avail-

5 TFP&C Report, p. 56. TFP&C analysts estimated that on an annual basis these associate membership dues for the federal unions and employee organizations amounted to between \$20 and \$25 million. Health insurance is thus a benefit of membership for such organizations.

6 Ibid., p. 62.

7 Ibid., p. 63.

Table 2
Choice for Federal Workers Has Led to a Doubling of Options

City	Share of Federal Employees	Number of Available Health Plans					
		1975			1988		
		Fee	HMO	Total	Fee	HMO	Total
Washington, D.C.	13%	18	3	21	31	15	46
New York	4%	14	2	16	25	11	36
Los Angeles	3%	14	3	17	25	14	39
Philadelphia	3%	14	0	14	25	15	40
Chicago	3%	14	2	16	25	15	40
San Francisco	2%	14	1	15	25	14	39
Baltimore	2%	14	0	14	25	12	37
Norfolk	1%	14	0	14	25	6	31
Boston	1%	14	1	15	25	8	33
St. Louis	1%	14	0	14	25	7	32
Denver	1%	14	1	15	25	8	33
Detroit	1%	14	1	15	25	9	34
Dallas	1%	14	0	14	25	9	34
Oklahoma City	1%	14	0	14	25	4	29
Miami	1%	14	0	14	25	11	36
15-City Total/Average	38%	14	1	15	25	11	36
Typical Smaller City	40%	12	0	15	22	2	24
Small Towns and Rural Areas	22%	14	0	15	24	0	24
Weighted Average	100%	14	0	14	24	5	29

Note: Fee = Fee for Service; HMO = Health Maintenance Organization
Not all HMOs necessarily available in entire metro area. For all areas outside D.C., excludes plans for agencies with virtually no employees outside D.C. Share of federal employees data is for 1982.
Source: Walton Francis, "How to Reform and How Not to Reform the Federal Employees Health Benefits System." Testimony presented to the Office of Personnel Management July 26, 1988 (revised 1991).

able per enrollee has declined to less than two dozen. The growth in HMO options has been dramatic.

While HMOs in the private sector have been growing fast, they are doing so faster in the FEHBP.⁸ One reason for this is that in the private sector, where

8 "HMO's currently enroll more than 13 percent of the population, with six states having more than 20 percent of their populations in HMO's." *Source Book of Health Insurance Data* (Washington D.C.: Health Insurance Association of America, 1990), p. 21. By 1990, HMOs accounted for 20 percent of the market share of employer provided coverage. *Medical Benefits*, September 15, 1991. In the FEHBP, HMOs now account for 26

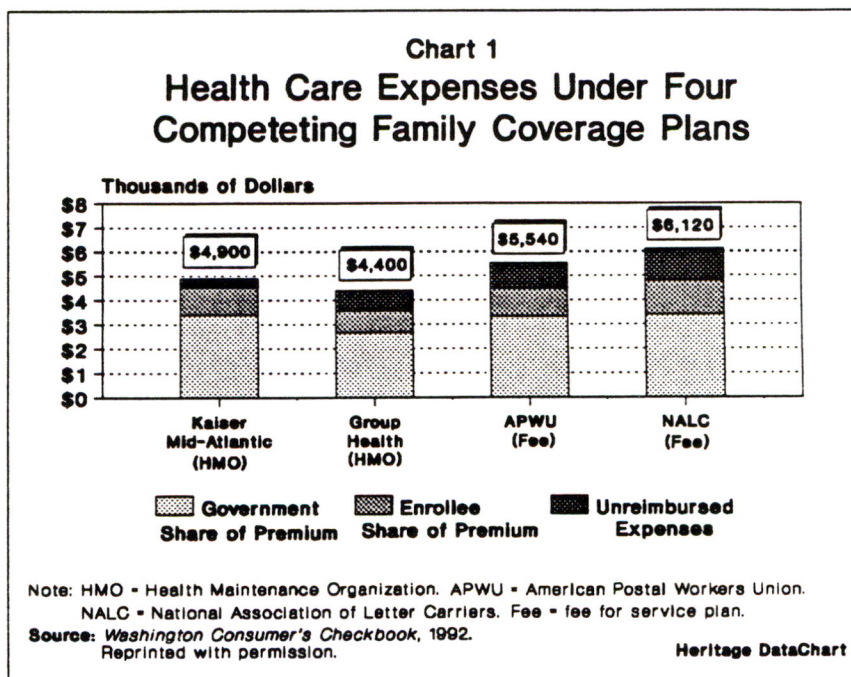
employees often are used to generous “free” plans “paid for” by their employers, employees resist being assigned to more restrictive plans, even though they generally cost less (to the employer, that is). In the FEHBP system, by contrast, employees can “shop around” among plans according to their combination of price and quality and keep the premium savings from lower-cost plans. In this open market, the price advantage of HMOs proves very attractive.

How the Government Helps to Pay Premiums

While the employee makes a decision on the basis of the stated premium price and benefits package, the government does make a contribution to the cost. The same is true for most workers in the private sector, because company-provided health plans are a tax-free fringe benefit—although if a family has no company plan and buys insurance directly, there is usually no tax break. In the federal sector, the help takes the form not of a tax break, but a direct payment calculated according to what is called the “Big Six” formula.

Under this formula, the government will contribute an amount equal to 60 percent of the “simple average” of the premiums for individual and family coverage of the six largest plans in the program. This means the federal government contributes a fixed dollar amount. The law further specifies that the contribution cannot exceed 75 percent of the premium, up to the formula dollar amount.⁹ Last

year, the maximum was \$1,570 for single employees and \$3,400 for families. Federal employees and retirees then pay the difference between the contribution and the premium cost. Chart 1 shows a



percent of total enrollment, up from just 10 percent in 1980.

- 9 Postal workers have a different and more generous formula arrangement, based on collective bargaining agreements. "The government pays about 62 percent of the total health premium for nonpostal federal workers, and about 75 percent for postal workers," says Mike Causey, "A Freeze That Pleases," *Washington Post*, October 1, 1991.

breakdown of costs to employees and the government in four typical plans.

The federal employee does not even have to write a check to his or her insurance company, or request reimbursement from the government for its share. Instead, the agency makes a payroll deduction each pay period for the employees' share of the premium, adds its own contribution, and transmits this money to an FEHBP Trust Fund, which then pays the plan chosen by the employee. For retired federal personnel, payments are made by the Office of Personnel Management from a special account.

The Benefits Available to Federal Workers

The FEHBP law gives the Office of Personnel Management, the federal government's central personnel agency, flexibility to negotiate rates and benefits of plans, consistent with Congress's intent to provide a sound package of benefits at reasonable cost. Congress has, on occasion, recommended that OPM press for certain specific benefits, but generally has stopped short of mandating them. OPM, which is responsible for the program, can require certain items to be included in all plans offered during open season.

This is quite different from the pattern at the state level, where state legislatures rarely have hesitated to enact sweeping mandates requiring insurers to include certain services in any plan they offer in the state.¹⁰ Why this difference between the states and the federal government in their propensity to mandate benefits? When a state mandates a benefit, companies foot the bill, and employees applaud state lawmakers for increasing their "free" employer-provided benefits. By contrast, if Congress mandates a benefit in all plans, there is no free lunch—the federal government and federal employees pay more.

This does not mean that federal plans offer only "bare bones" coverage. In fact, federal workers often demand, and receive, the reasonably generous benefits they choose to pay for. As Mike Causey the *Washington Post's* veteran reporter on civil service affairs reports: "The good news for federal workers and retirees who have until December 9 to pick a health plan to cover them and their families next year: all of the plans are good."¹¹ Virtually all the competing federal plans offer a wide range of services, including hospital and physician services, tests, immunizations and preventive examinations, kidney dialysis, and a limit on total out-of-pocket costs.

10 Federal law preempts state health benefit mandates for plans competing in the FEHBP and also prohibits state taxation of plan premiums.

11 Mike Causey, "Healthy Insurance," *Washington Post*, November 13, 1991.

HELPING CONSUMERS CHOOSE

Some critics of consumer choice in health care claim that a big difference between medical purchases and, say, buying a car, is that easily digestible information for consumers regarding health care does not exist. This, they say, makes informed choices impossible.

To be sure, there is little information to help private sector employees buy health plans. But this is because few families have the chance to make a choice from a wide range of plans. Without a market for advice, products offering advice will not develop. Such products, of course, have been developed offering advice for how to purchase other sophisticated or complicated goods and services like life insurance, real estate, automobiles, or stocks and bonds.

Similarly there is plenty of advice for the nine-million-strong consumer market for FEHBP health plans. Some comes from the federal government. The Office of Personnel Management sends each employee an unbiased description of the benefits and employee cost of each plan. Federal agencies add to this information by distributing material to employees and sponsoring "health fairs" that outline what is available to employees and their families. Members of Congress with large concentrations of federal employees or retirees in their districts even hold weekend "health fairs," inviting private health insurance and government analysts to discuss the merits and drawbacks of the various FEHBP plans.

The Private Sector Information Explosion

Official efforts pale by comparison to the sophisticated and ubiquitous private information available to federal employees and the public discussion that takes place each open season. For instance, from daily columns in the *Washington Post* to programs on talk radio, federal employees in the Washington, D.C., area can obtain the latest information on each year's health care offerings—how much plans are going to cost, which has the best dental benefits, which has the best catastrophic coverage, and so on. In addition, the companies and employee organizations market their plans through brochures and advertising, especially in areas where there are heavy concentrations of federal employees. Carriers take to the airwaves, post billboards in strategic locations, or advertise in newspapers, buses, and subways. And they respond to the demand for quality information in plain English, with minimal jargon.

Even more significant is that major consumer organizations provide the same kind of information to federal workers buying health plans as they do for other Americans purchasing a new car. Each year in the Washington D.C. area, for example, congressional and federal employees can purchase the *Checkbook's Guide to Health Insurance Plans for Federal Employees*, with detailed ratings and cost analyses of all the health insurance options available. This annually makes the "best seller" book list in Washington, and is published by Washington Consumers Checkbook, the same consumer organization that publishes information on where Washingtonians can get the best bargains on everything from VCRs to autos to household appliances.

Federal employee organizations, meanwhile, distribute information to their members. The National Association of Retired Federal Employees (NARFE), for instance, publishes an annual "Open Season Guide." And, of course, federal employees do in health care what they and other Americans do when they make other major purchases: they talk to experts they trust and they talk to their co-workers. They ask their family physicians or their agency benefits expert about rival health plans, and they talk to each other about their experiences with plans.

During open season, the cafeterias of the Treasury, the shuttlebuses to the State Department, and the subways to the suburbs are scenes of countless discussions and debates about the pros and cons of different health plans. It happens because federal employees have the right to choose and the incentive to choose wisely.

Refuting Experts. The wide availability of understandable information and expert advisors refutes the contention that only experts can make intelligent decisions about health care insurance. And even though some federal employees, like consumers in other markets, actually grumble that the wide range of annual options is annoying or confusing, very few would want OPM to end open season. In fact, serious proposals to postpone open season have met with implacable employee opposition.¹²

Employees use the information available to them to change plans when they find it advantageous and to save money. One effect has been a steady move to lower cost options such as managed care plans, including HMOs. In 1987, for example, approximately 175,000 enrollees moved from fee-for-service plans to HMO plans, with costs that were approximately 20 percent less than comparable fee-for-service plans.¹³ As economist Walton Francis notes, with average enrollee premiums in 1988 dollars (both employee and government share) running about \$2,430 for fee-for-service plans, and about \$2,100 for HMOs, the \$330 in savings per enrollee, for HMO enrollment alone generated "savings for both the employees and the taxpayers on the order of \$50 million in 1987."¹⁴ Says Francis, "Those non-expert federal employees who supposedly cannot choose rationally among a large number of plans have succeeded in becoming well enough informed to better their own health insurance while saving both themselves and the government hundreds of millions of dollars annually."¹⁵

12 Faced with an unforeseen deficit in the FEHBP in 1981, for instance, the Reagan Administration announced postponement of the annual "open season". Both employee organizations and Members of Congress expressed outrage. Federal union representatives responded with demands in formal hearings that Congress make open season mandatory, thus removing OPM's administrative authority over the process.

13 Walton Francis, "How To Reform, And How Not To Reform, The Federal Employees Health Benefits Program," Testimony presented to the United States Office of Personnel Management, July 26, 1988 (revised 1991), p. 6.

14 *Ibid.*

15 *Ibid.*, p. 7.

THE LACK OF RED TAPE IN THE FEHBP SYSTEM

Compared to most government programs, which are accompanied by thousands of pages of detailed and confusing regulation, there is little red tape in the FEHBP. Just 1 percent of each plan's premium cost is set aside for OPM's administration of the system. This covers such things as OPM's role in running the annual "open season" and operating the Federal Employees Health Benefits Trust Fund, out of which premiums are paid to the carriers, as well as administering a wide range of services for retirees. OPM also requires plans to put aside three percent of premiums income in a reserve to pay for "current and future claims liabilities" and strengthen the financial position of the program.

Compared with the giant Medicare program, which is the prototype for the government-payer system for national health insurance advocated by some in Congress, the consumer-driven FEHBP is administratively far simpler despite the existence of an enormous number of plans.

Cumbersome Medicare. In Medicare, the government literally dictates what benefits will or will not be included, such as catastrophic coverage, through a cumbersome and often controversial legislative and regulatory process. In contrast, the addition of benefits in the FEHBP is relatively painless, effected through private sector-style negotiations, and finalized for each and every employee through personal choice. While Congress and the managers of Medicare program devote enormous resources to implementing intrusive and complex "cost control" features, the managers of the FEHBP historically have refrained from such intervention. Nevertheless, truly efficient market forces, such as employees' voluntary choice of low cost plans with higher coinsurance and deductibles, makes this unique federal program a leader in health care cost control. While Medicare employs thousands of personnel to administer the program, including the negotiation and monitoring of carrier contracts, the promulgation of thousands of pages of detailed guidelines, rules and regulations, the FEHBP plans themselves do much of the actual administration, including claims processing, and the government's administrative staff is small. Meanwhile, OPM has helped to keep overhead costs down by making some significant managerial improvements during the past two years.¹⁶

16 Even more can be done. But any reform the FEHBP should be undertaken with proper respect for its general record of success. As Professor Alain Enthoven of Stanford University, a longtime student of the program, has noted, "The administrative expense of the Office of Personnel Management, the managing agency, is less than a quarter of one percent of the revenue. William Hsiao, an actuary at the Harvard School of Public Health, did a comparison of the costs of claims administration under Medicare and under the FEHBP. He found that the average cost to process a claim was 26 percent higher in Medicare than in the Federal Employees program, after dissimilar functions were eliminated from the comparison." Alain Enthoven, *Health Plan: The Only Practical Solution To The Soaring Cost of Medical Care* (Reading, Massachusetts: Addison-Wesley Publishing Company, 1981), p. 83.

COST CONTROL IN THE FEHBP

Like ordinary Americans, most lawmakers recognize that the best mechanism to control costs without sacrificing economic efficiency is through consumer choice in a competitive market. But there has been an assumption that this mechanism cannot operate in health care because consumers and providers are not greatly influenced by differences in prices in making choices. In Medicare, Medicaid, and even many private company plans, this has led to the price controls, regulation, and other features of central planning. But these have proven no more effective in achieving efficiency in the U.S. health care system than in the communist economies of Eastern Europe.

FEHBP explodes the myth that consumer choice is not the key to cost control in health care. From FEHBP's inception, consumer sensitivity to price and quality—not regulation or price controls—has been at the heart of the cost control.

This sharply distinguishes FEHBP from other federal programs, like Medicare. It also distinguishes FEHBP from conventional, employer-based health insurance. In these private sector plans, consumer choice based on price does not generally function because very few employees have any idea of the price of their health benefits. And, because the tax code gives no breaks to an employee who would buy a more economical, non-company plan to that offered by the employer, in the private sector health insurance world, there is no incentive to shop around, in the way that federal workers do. Instead, a health care plan is treated as a "free" benefit that comes with the job.

Twin Principles. Congress explicitly based FEHBP on the twin principles of consumer choice and market competition. Liberal lawmakers have emphasized these principles within the federal system covering themselves, even while many of these lawmakers seem to reject the same principles when considering a new system for all other Americans. Said Representative Mary Rose Oaker, the Ohio Democrat and former Chairwoman of the House Subcommittee on Compensation and Employee Benefits, in 1984:

The two fundamental principles that grew out of enactment of the 1959 law were: freedom of choice and competition...To ensure this variety of benefit packages to all federal employees, retirees and dependents, at a reasonable cost, the Congress designed a system that promoted competition among a large number of carriers.¹⁷

17 Rep. Mary Rose Oaker, "Opening Statement," on "New Participating Organizations in The Federal Employees Health Benefits Program," Hearings, United States House of Representatives, Subcommittee on Compensation and Employee Benefits, Committee on Post Office and Civil Service, October 2, 1982.

Three years earlier, then Representative Michael Barnes, the Maryland Democrat, who chaired the Congressional Federal Government Services Task Force, told a congressional panel:

Freedom to choose among plans, and thereby to maintain competition among plans, has been the system's first line of defense against skyrocketing premiums. It is a theme sounded repeatedly throughout the Act's legislative history.¹⁸

This dynamic of consumer choice within a wide range of competing health plans has helped keep costs in check in the FEHBP. According to a 1989 study conducted by the Congressional Research Service, "FEHBP total premiums have increased by an average of 12 percent annually from 1980 through 1988, compared to the average 14 percent rise incurred by private sector plans during the same period."¹⁹ Since 1989, the general trend line of average premium increases in the FEHBP has been going down, dipping into the single digits. For this year, average premium increases in the FEHBP are projected at 8 percent.²⁰

But the relative performance of the FEHBP is even better than the total numbers show. A number of factors, for example, should be driving up FEHBP costs. FEHBP imposes no pre-existing condition requirements on its enrollees, and FEHBP covers 1.5 million retirees, plus their spouses and survivors.

In the private sector, only one-third of companies offer health care coverage to their retirees, and the companies that do are cutting back on these benefits.²¹ But

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- 18 Rep. Michael Barnes, Testimony on The Federal Employee Health Benefits Program before the Compensation and Employee Benefits Subcommittee, House Post Office and Civil Service Committee, November 19, 1981.
- 19 U.S. Congress, House, Committee on Post Office and Civil Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*. A Report Prepared by The Congressional Research Service. Committee Print 101-5, May 24, 1989, p. 50. Hereafter cited as *CRS Report*. It should be noted that what would have been dramatic premium increases in the FEHBP during the 1980s were restrained by OPM's unusually decisive management, including limiting or reducing coverage of dental and mental services to combat an unforeseen deficit in 1982, as well as the use of plans' premium reserves to give federal employees a \$1 billion premium rebate in 1986. Moreover, OPM introduced stronger coinsurance and deductible requirements for controlling costs. "In addition, federal enrollees have taken advantage of the choices offered them by moving to lower-cost plans in order to escape rising premiums." *CRS Report*, p. 255.
- 20 "Increased Enrollee Benefits, Low Rate Increases, Highlight 1992 Federal Health Benefits Program Changes," *OPM NEWS*, September 15, 1991. A. Foster Higgins, an international employee benefits consulting firm based in New York, reports that employers' 1991 health care costs nationwide rose 12.1 percent, and that the annual increase for this year are expected to be "higher." Milt Freudenheim, "Health Care Costs Up 12.1% Last Year, A Study Says," *The New York Times*, January 28, 1992.
- 21 According to a 1991 study by the Employee Benefits Division of Northwestern National Life Insurance Company of Chicago, only 33 percent of private companies offer retiree health care. Citing a 1990 study by William M. Mercer Inc., Northwestern analysts note that 26 percent of the companies that do give retired workers health coverage are planning to limit it for current retirees and are not planning to offer it for future retirees. Northwestern National Life Insurance Company, *Retirement At Risk: The Growing Threat of Health Costs*, presented at a forum at the National Press Club, Washington D.C., November 14, 1991, p. 5.

in the FEHBP, retirees make up about 40 percent of total enrollees, including a large number of federal workers ineligible for Medicare, including those who retire early at age 55 with thirty years of service).²²

Retirees, of course, consume more health care services than do those of working age.²³

Why the FEHBP Out-performs the Private Sector

It is not often that a federal program is a better model of a free market in action than the equivalent private sector program. But the FEHBP is for two reasons. First, the federal government created a system based on consumer choice and market competition—a system in which market forces, not regulation, force improvements in efficiency and encourage innovation among providers. Second, the tax system affecting non-federal workers has so distorted the market for health care in the private sector that the power of consumer choice has been suffocated.

The tax code gives American workers an unlimited tax break on health plans if—and only if—the health plans are provided by their employer. If the employer does not offer a plan, or if a worker noticed that some other plan actually was better value for money, in almost no instance does the tax code give the worker any tax relief for selecting a better plan.

The tax benefits for private sector workers, moreover, grow as the generosity of the company plan grows. So, union bargainers have an incentive to press for tax free health benefits rather than for taxable wage increases. This tends to push up health spending and health costs, and blunts employee sensitivity to these costs. By contrast, the federal government contributes a maximum amount to each employee. In 1989, this averaged \$2,861.²⁴ Unlike the unlimited tax break for “free” company plans in the private sector, this means there is a much greater sensitivity to the price of health benefits by enrollees in the FEHBP.

Private employer-based insurance practices, heavily and artificially influenced by the federal tax code, have led to two characteristics of private coverage that now are routinely described as a crisis. One is soaring health care costs, due to the lack of price sensitivity by employees. The other is that a family’s employer is the key to its health care. This not the case in other areas of insurance, like life insurance, car insurance or home-owner’s insurance. Only in health care is the ex-

22 Richard Ruddick, Vice President, Federal Employees Health Benefits Plans Division, CNA Insurance Companies, *Statement Before the House Subcommittee on Compensation and Employee Benefits*, May 18, 1988, p. 8. As Ruddick demonstrates, an FEHBP retiree, eligible for Medicare, has health insurance claims costs of 140 percent of those of an active federal worker. But for a federal retiree without Medicare, the health insurance claims costs are 262 percent of those of an active federal worker. *Ibid.*, p. 10.

23 According to analysts at Northwestern National Life Insurance Company, each American age 65 or older consumes an average of \$5,360 per year in health care services, compared to an American under the age of 65 who consumes an average of \$1,290. *Retirement At Risk*, p. 4.

24 *CRS Report*, p. 19.

tent and availability of insurance determined by one's employer. And only health benefits suddenly are at risk if an American changes jobs or is temporarily unemployed.

LESSONS FOR HEALTH CARE REFORM

Opponents of consumer-based health care reform in Congress and the press often argue that Americans just are not competent to make wise choices about health care plans. They say that Americans cannot weigh price, value and benefits. They also say that such a system would not constrain costs. Therefore, they insist, while consumer choice may sound good in theory, and works in the rest of the economy, it could not work in health care.

This is flatly contradicted by the experience of the FEHBP. And, it is especially ironic that the lawmakers who reject the idea of consumer choice in health care actually exercise choice themselves every year in the FEHBP and resist every effort to take away that choice.

The experience of the FEHBP has many lessons for lawmakers now engaged in the debate over reforming the U.S. health care system—and each of these lessons point to the workability and desirability of a universal health care system based on the kind of consumer choice taken for granted for federal workers—and members of Congress. Among the salient lessons:

Lesson #1: Ordinary Americans are quite capable of making sensible choices regarding their health care plans.

Federal workers are not the wide-eyed hapless consumers portrayed by opponents of consumer choice in health care. They do not shop around in a bewildering market, falling prey to powerful insurance companies. On the contrary, consumers indisputably have the upper hand and force plan providers to adapt to their demands or suffer the consequences. Big insurance carriers like Blue Cross and Blue Shield find themselves, each year, in a bruising battle for market share with plans offered by entrepreneurial employee organizations like the Mail Handlers and managed care plans.

One valid criticism of the FEHBP actually turns out to underscore the power of consumer choice. That is the problem of “adverse selection,” meaning that lower-risk enrollees, free to shop among competing health care plans each year, tend to gravitate to leaner, lower cost plans, resulting in the cost of serving higher-risk individuals, concentrated in comprehensive plans pushing up the cost of more comprehensive plans. But as Ben Lytle, President and CEO of the Associated Group, an insurance company based in Indianapolis, Indiana, explains, “adverse selection is the insurance industry’s term for ‘the consumer outsmarted us’”. He figured out that he could buy a policy and get more in benefits than we charged him in premiums.”

Still, adverse selection is a problem for insurers in the FEHBP because some plans end up with a high number of costly enrollees. It would be largely avoided

if the government's share of plan costs were revised to allow plans to charge higher prices for high-risk individuals, such as retirees, without the enrollee's share of these costs rising significantly. For opponents of consumer choice, adverse selection presents the supreme conundrum: they cannot logically argue that adverse selection resulted from consumer choice based on self interest, while simultaneously holding the position that consumers are incapable of making rational choices.

Lesson #2: Consumer information becomes readily available — once consumers are permitted to make choices.

The ready availability of consumer information in the FEHBP exists because nine million Americans have the right to choose a plan. If consumer choice of health plans were available to all Americans, there would be an explosion of usable consumer information.

Lesson #3: Consumer-choice is a simpler and more effective way to control costs than regulation and price controls.

While the huge federal Medicare program, America's foremost experiment with single-payer government health care insurance, is characterized by a mountains of increasingly unintelligible regulations governing doctors and patients, FEHBP remains simple. Medicare is moving actively toward price controls and other features of centralized planning. FEHBP, meanwhile, has been relatively "passive."²⁵ And largely devoid of consumer choice, private sector health care plans are finding it hard to control costs, with larger average premium increases than the FEHBP, even though most private sector health care plans do not even cover high cost retirees.

Lesson #4: When consumers pay premiums directly, albeit with government help, they resist mandates which raise health costs.

If Congress mandates a benefit in a system where there is direct and immediate cost-sharing between the government and the employees and retirees, the direct and immediate financial impact of this mandate shows up in higher costs for both, as well as for the taxpayers. This has made Congress very resistant to the kind of special interest medical lobbying that has been so successful elsewhere.

Lesson #5: A consumer-choice system is simple and inexpensive to administer.

Even though they individually purchase their health insurance package, congressional and federal employees and retirees in the FEHBP do not have to worry about making sure that their insurance premiums are paid; the federal government, as employer, pays them to the carriers. A payroll deduction is made by the

²⁵ CRS Report, p. 239.

federal government each pay period, every two weeks, and the funds are deposited in a government account for transmission to the private carriers.

In designing a consumer based health care system for America, where families would have the option to choose among many different types of plans with the same tax breaks, employers, like federal agencies in the FEHBP, also could be required to make payroll deductions for premiums for workers and transmit these premium payments to the insurance carriers of the employees' choice.

Lesson #6: A consumer-choice system is better than regulation in encouraging cost-saving health care innovations, like managed care.

When consumers can choose health plans on the basis of quality and price, providers that use innovative ways to deliver care at lower cost have a competitive advantage. When employees pay for the plans, consumers understandably want generous plans without regard for value. That is why managed care, union plans, and other innovations are common in the FEHBP but rarer in the private sector or in "all-payer" programs like Medicare. Innovation similar to the FEHBP could be expected if all Americans had a choice of health plan.

If a federal worker moves from the Treasury to the Pentagon, or takes a job on Capitol Hill, they keep the same health plan and there is no interruption in benefits. If private-sector employees lose their job or change jobs, they do not lose their homeowners insurance, their auto insurance or their life insurance. They only lose what is arguably their most important insurance—their family's health insurance. With a consumer based system, in which the tax relief goes directly to individuals and their families, either in the form of credits or vouchers, irrespective of where they work, employees could choose a health coverage that had nothing to do with their place of work, and would accompany them from job to job.

HOW CONGRESS SHOULD REFORM AMERICA'S HEALTH CARE SYSTEM

It would be relatively simple for Congress to amend current law so that every working American family in effect would have the same type of choices available to Congress and other federal employees. Doing so would require three basic steps.

First, the tax treatment of health care would have to be reformed, such that families would have the same system of tax relief wherever they chose their health plan and wherever they worked.

Second, the tax relief would have to be changed to give more help to lower-paid workers and those facing higher insurance and medical costs, and a limit on the tax break for plans purchased by affluent Americans. These changes would deal with most of the adverse selection problem experienced in the FEHBP system.

And third, there would have to be some changes in insurance regulations to discourage plans from turning down potentially high cost enrollees or charging them prohibitive premiums.

A proposal to accomplish this has been advanced by The Heritage Foundation. Known as the Consumer Choice Health Plan, this would replace the current tax-free fringe benefit status of company-provided plans with a refundable tax credit for buying health insurance or medical services. All families would be required to obtain at least a basic plan. And insurance companies could not cancel coverage because of high claims, nor could they refuse to cover an individual or apply a premium surcharge higher than a specific percentage. In addition, just as in the FEHBP, employers would be required to make a payroll deduction on behalf of each employee and send premium payments to the plan chosen by the worker.

CONCLUSION

Members of Congress would not even think of giving up the benefits of choice and competition in their own health care system. Indeed, they have taken pains to exempt themselves from many of the "reforms" they would impose on all other Americans.²⁶ Lawmakers should reflect on this in developing a national health care system for all Americans.

Instead of trying to build upon the employer-based model that does not restrain costs and contains many other flaws, or instead of introducing a massive nationalized system based on rationing, price controls and all the other crude instruments of central planning now being rejected by their former admirers throughout the world, Congress should adapt and refine the system that works so well for federal workers: a system characterized by consumer choice and competition. This system should be permitted to all Americans.

By building upon these principles, Congress would improve its model Federal Employee Health Benefits Program and also lay the foundation for a genuine consumer-based national health program. Driven by the same dynamics of consumer choice and market competition that work so well in the rest of the economy, such a consumer-based system would mean affordable and adequate coverage for every American family. What is available for Congress and its employees should be made available to every American family.

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Deputy Director of Domestic Policy Studies

26 For example, Senator George Mitchell's "play or pay" proposal (S. 1227), which is one of the leading health care reform proposals now before Congress, explicitly exempts members of Congress, their staffs, and other federal employees. See Edmund F. Haislmaier, "The Mitchell HealthAmerica Act: A Bait and Switch For American Workers," *Heritage Foundation Issue Bulletin* No. 170, January 17, 1992.

HERITAGE TALKING POINTS

A Checklist on Vital National Issues

A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS

PART I: THE DEBATE OVER REFORM

By Stuart M. Butler, Ph.D.



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A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS PART I: THE DEBATE OVER REFORM

By Stuart M. Butler, Ph.D.

INTRODUCTION

The United States health care system has come under increasing criticism in recent years and is fast becoming a central issue in this year's national election. The reason: although the U.S. system has obvious virtues, there is widespread dissatisfaction with the system among ordinary Americans.

For most of these Americans, the quality of care is not the central problem. Indeed, the quality of the U.S. system is the envy of the world. People flock to America when they want the best—even people from Canada, despite its vaunted national health system. And Americans rarely go abroad for health care.

The chief concern of Americans, surveys show, is with the way in which health benefit plans are organized and financed. They worry about losing benefits when they change jobs or joining the ranks of the uninsured when they are laid off. They fret about being wiped out financially by a disease that is not covered by their plan or whose cost exceeds their coverage limits. They complain about the seemingly endless paperwork associated with even a minor insurance claim. And if they are employers, they are frustrated at their lack of success in trying to hold down exploding health benefits costs.

Fundamental Reform Sought. Various bills before Congress, as well as proposals under discussion around the country and a plan unveiled recently by the Bush Administration, seek fundamental reform of the U.S. health care system. Some would replace it entirely with a government-run system like that of Britain or Canada. Others would require all employers to provide at least a basic package for all their workers and their families, or pay a tax to fund government-organized health benefits for those without company insurance.

Others still, including a proposal from The Heritage Foundation, suggest a different approach. These proposals start from the premise that the health system is in such bad shape because the tax and regulatory treatment of health plans has distorted the health system in such a perverse manner that anything resembling a normal market has broken down. What these proposals would do is change the rules so that consumers would have the incentive and the means to choose the

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health plan they want, and the ability to afford at least a basic plan.

Under the Heritage Foundation Consumer Choice Plan, which will be discussed in Part II of this *Talking Points* series, the current tax break for employer-provided health benefits would be replaced with a tax credit for health plans or medical services obtained from any licensed source, not only an employer.¹ Like the other major approaches being debated, this relatively simple change would have profound effects on the health care system.

This *Talking Points* Part I examines the reasons for the concern about health care. It then summarizes and analyzes the major options for reform.

WHAT'S WRONG WITH THE U.S. HEALTH CARE SYSTEM?

The first thing to understand is that the U.S. health system actually is several systems. There are **government-operated** systems, such as the Veterans' Health Administration, in which hospitals are owned by the government and doctors are government employees. These are much like the core of the British National Health Service.

Then there are **government financed and regulated** systems—chiefly Medicare and Medicaid. According to the Congressional Budget Office, Medicare covers about 27 million elderly Americans (another 3 million disabled individuals also are covered) and Medicaid provides primary coverage for about 15 million non-elderly Americans. In these programs the government pays private doctors and hospitals set fees to treat certain individuals. These function much like the Canadian system.

Then, for the vast majority of working Americans, there is a system of **employer-sponsored private health insurance**. About 150 million Americans under the age of 65 are covered in these company plans.

Q. What is driving the calls for major reform?

A. While there are concerns about every sector in this system, the **political debate today centers on the private insurance system**. While most Americans do not fault the quality of the health care they receive from employer-provided health plans, they grumble loudly about other features. Among them: they can lose coverage or have worse coverage if they change jobs; employers always seem to want to cut benefits or make the employee pay more for coverage; mountains of paperwork accompany every claim.

¹ See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Using Tax Credits to Create an Affordable Health System," Heritage Foundation *Background* No. 777, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of the American Medical Association*, Volume 265, May 15, 1991.

Q. So why do most Americans have company-provided plans?

A. It is a historical accident driven by two connected events. First, when wage controls were instituted during World War II, firms encountering severe labor shortages increasingly expanded fringe benefits, especially health benefits, to attract workers. Second, the Internal Revenue Service ruled after the war that such health benefits would, without limit, be free of federal income and Social Security tax. These events, not any national consensus that employers are the best people to organize health benefits, brought about the system that determines the health care available to most Americans.

Q. How does the tax law encourage employer-based plans?

A. Under current law, if a worker accepts a health package from his or her employer, the insurance element of that package is tax-free.² Any out-of-pocket payments by the employee (such as deductibles or items not included in the plan) are not tax-free and must be paid for in after-tax dollars.³ If the employer does not provide insurance or the employee prefers some other plan, the employee gets no tax break for buying insurance or medical services himself.

Q. Why does this tax treatment cause problems?

A. The employment-based system artificially encouraged by the tax code leads directly to the problems commonly cited by Americans as the reasons why fundamental reform is needed. Among them:

Problem #1: If you change your job, you must change your health coverage; if you lose your job, you lose your coverage.

Because health insurance for most families is employment-based, when a worker changes or loses jobs, suddenly the family's health coverage changes or is lost. If the new employer provides insurance, it can mean a major change in benefits. Sometimes families lose benefits they like; often they will have to switch to a new doctor that is included in the new plan. Often a change of job can mean financial disaster. Even if coverage is available from the new employer, usually there are "pre-existing condition" clauses in the plan, meaning the family will not be covered for an existing illness. And if

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- 2 Including cases where the employer "self-insures," that is, carries the insurance risk himself, and cases where the insurance takes the form of monthly payments to a pre-paid managed health plan, such as a Health Maintenance Organization (HMO). For self-employed individuals, only 25 percent of the cost of a plan is tax-free.
- 3 There are certain exceptions, the main one being a deduction available under Schedule A of the tax form (itemized deductions) for out-of-pocket costs that exceed 7 1/2 percent of adjusted gross income.

the new employer does not offer insurance, or the worker becomes unemployed, the family must gamble with its health or buy its own coverage—without a tax break.

This is why so many of the 34 million Americans who are uninsured at some time during a year actually are workers—sometimes well-paid workers—or the dependents of workers. In fact, about 80 percent of uninsured Americans are workers or the dependents of working Americans.

Q. But is this problem really due to employment-based insurance?

A. Yes. This so-called portability problem does not occur with other major forms of insurance or major household expenditures. When a worker changes jobs he does not suddenly lose his life insurance and have to take a medical examination and apply at perhaps higher life insurance rates—or be turned down as a bad risk. He does not lose his car insurance. Nor does he have to refinance his mortgage. The reason is that these important items are portable because they have nothing to do with employment. And more important, the beneficial tax treatment of, say, life insurance or mortgage interest has nothing to do with employment. Only a family's health insurance availability and tax treatment depends on the bread winner's place of employment.

To understand the absurdity of today's tax treatment of health care, imagine a different America. In this America, the only way to receive a tax break on life insurance payouts or whole life insurance investments is to have insurance provided by an employer. And suppose, by contrast, a tax break is available for health plans whatever their source. The newspapers then would be full of heart-rending stories about families losing life insurance when they changed jobs, of widows left penniless when an older worker was laid off and could not afford a new policy because of a heart condition. But there would be no stories in such an America about workers losing health benefits when they changed jobs, because that would not affect health insurance.

Problem #2: If you work for a small firm, you are more likely to lack insurance.

Like other forms of insurance, the cost of health insurance generally is less when people are covered in a large group. Among the reasons: individual risks can be spread by the insurer across the group and so there is a smaller "risk premium" charged for a large group policy; paperwork costs associated with premium collections and marketing are smaller. This is why buying insurance through an organization (such as an automobile club or some other membership group) normally is cheaper. With employment-based health insurance, this means that the firm with 3,000 employees generally can get a much better rate than a firm with three employees. Worse still, the small firm can find its premium costs skyrocketing if it hires a fourth employee who has a large family or a checkered medical history. The reason: the cost of one high-risk employee cannot be spread widely.

The high cost of health insurance for small groups is why small employers are much less likely to provide health benefits and thus why so many uninsured Americans work for these firms. Some 43 percent of uninsured workers are employed by firms with 25 or fewer workers. It is also why all attempts to encourage wider employment-based insurance run into an enormous problem—how to make insurance affordable for small firms.

The fact that an individual works for a small firm, of course, does not affect the cost of his life insurance, his homeowner's insurance, or his auto insurance. This is because the premiums are not based on employment groups. To be sure, an employee of a small firm could join a large group to obtain the economies of scale and risk-spreading to reduce rates—perhaps a health insurance plan organized by a union, his church, the state farm bureau, or even an automobile club. This does not happen because there would be no tax relief for plans obtained through these non-employer groups.

Problem #3: If you are well-paid, you get a large tax break for health coverage. If you are low-paid, you get little or nothing.

The tax-free fringe benefit status of company-based plans is much like a normal tax deduction (except that there is also relief from Social Security taxes). This means that the higher the tax bracket of the employee, and the more generous the health plan, the larger the tax break. This "tax exclusion" was worth \$66.6 billion in 1991 in federal taxes avoided, and another \$8.3 billion in relief from state taxes.⁴

But according to Lewin/ICF, a Washington, D.C.-based econometrics firm specializing in health spending analysis, nearly 26 percent of this tax relief goes to households with incomes in excess of \$75,000 per year, and just over 6 percent to households earning below \$20,000. At the federal level, a household earning \$100,000 or more has a tax break worth an average of \$1,463 each year. A working family earning under \$10,000 gets an average of \$50 in tax help. If the family has no health plan (far more common for low-paid workers than high-paid workers), there is no tax break at all.⁵

What this means is that the revenue cost of the tax exclusion is heavily skewed towards upper-income earners. This in turn means the government gives little or no help to those working Americans who find it hardest to afford medical care. The system is great for Chrysler chief Lee Iacocca, but terrible for the part-time janitor at a local Chrysler dealership.

4 The relief from federal income tax was \$39.7 billion. The relief from Social Security (including Medicare) taxes was \$26.9 billion.

5 Estimates prepared for The Heritage Foundation by Lewin/ICF, January 15, 1992.

Problem #4: The employer-based system encourages overinsurance, higher paperwork costs, and higher premiums.

The tax treatment of company-based insurance means that a \$10 headache prescription or a \$30 routine teeth cleaning covered by an insurance plan is tax-free while a \$5 bottle of Tylenol or a \$1 box of dental floss is not. Consequently, workers and unions press for even the most routine items to be included in health insurance plans. This means that company-provided health plans often "insure" workers and their families against completely predictable minor health costs. And every time a small cost is incurred, forms have to be filled out and processed, adding to the cost of the health plan. But this costly system of overinsurance is quite rational for the employee, even though it means high premium costs (which ultimately come out of his total compensation, of course) because it means these routine, minor costs are tax-free.

Workers would never insure themselves in this way for other aspects of their daily life, such as automobile care. Americans understand well that if they were to "insure" themselves against the cost of an oil change, new tires, tune ups, or even (to complete the analogy with routine health care) the cost of the weekly gasoline fill-up, the price of the extra insurance would far exceed the cost of paying for the items themselves. That is also the case for health insurance, according to a study by the Dallas-based National Center for Policy Analysis. Nevertheless, workers press their employers to overinsure them for health care because insurance is tax-free and because they live under the illusion that company benefits somehow are free.

Problem #5: It is extremely difficult for employers to hold down costs.

In any normal major retail purchase, say of a life insurance policy, or a car, or a house, there is a buyer and a seller. The buyer pays the seller and is the one who consumes the product or service. There may be expert intermediaries involved (a broker or a real estate agent, for instance), but they represent one of the sides in the transaction.

In employment-provided health insurance the buyer-seller relationship is very different because a third party (the employer) enters the picture. The employer is not the consumer of health services yet he buys the coverage and pays the hospital or doctor (directly, if the employer self-insures, or indirectly if the employer buys health insurance).

This third party arrangement leads to a very different relationship between the consumer (the patient) and the seller (the doctor or hospital) in health care transactions. For the patient, it means the cost of a service usually is of little or no concern, since the bill will be sent to the employer.

To be sure, as labor economists point out, the cost of company health coverage is part of the employee's total compensation package and thus ultimately comes out of the worker's pay, just as the "employer's share" of So-

cial Security taxes does. But the employee sees little or no direct relationship between the cost of a particular treatment and the size of his paycheck. Thus, there is little or no incentive to economize. Similarly there is no reason for the doctor to mention cost when suggesting a test or procedure to the patient.

To understand what this means for costs, imagine if companies “insured” their workers for the cost of buying and repairing the family car. Families would have little reason to bargain with a dealer — why would they accept a stripped-down car when they could have one loaded with options and “paid for” by their company? And car mechanics would do very well. A squeak under the hood? Why not have the repair shop take the engine apart? Or better still, why not put in a new engine? After all, the company is paying.

In company-based health insurance, then, the patient and doctor are concerned about benefits, but not costs. Meanwhile, the company is concerned about costs, but not benefits. This is a recipe for two things: rapidly rising costs and friction between employees who do not want to lose benefits and employers who want to cut costs. Employer health care costs are surging. They rose 21.6 percent in 1990 and 12.1 percent in 1991. The rate in 1991 was about four times the general rate of inflation. But as employers fiercely resist these efforts. According to the AFL-CIO, about three-fourths of strikes today center on health benefits.

THE REFORM OPTIONS

There are three principal ways to reform the health care system for working Americans (leaving aside reform of Medicaid, Medicare, and other health programs). Each of them places somebody in firm control of how many health care dollars are spent and who gets what services. Each has profound implications for the economy and the health care of American families.

Option One: This first plan is known as “**Play or Pay.**” This actually would build on the current employer-based system while expanding Medicaid. In this system employers and the government would make the major decisions regarding what services Americans will receive and how much will be spent.

Option Two: The second plan recognizes that employer-based insurance is the heart of the problem. Known as the “**Single-payer**” or “**Canadian**” approach, this would substitute the government for employers, with the government paying for health care out of taxes and paying doctors and hospitals according to fees negotiated between providers and the only legal buyer—the government. The government also would set total spending levels for health care in America.

Option Three: The third plan, known as the “**Consumer Choice**” model, also recognizes the flaws of the employment-based system. But instead of letting the government take over, it would give consumers the ability to make the major decision in health care spending. It would do this by changing the tax treatment of health purchases to enable families to purchase their own plans.

HOW THE PLAY OR PAY APPROACH WOULD WORK

Under this approach, employers would be given a choice: provide at least a basic comprehensive health package for workers and their families or pay a payroll tax to fund coverage under a public program, similar to Medicaid. The main bill before Congress based on play or pay (S. 1227) is sponsored by Senate Majority Leader George Mitchell, the Maine Democrat.

This legislation would mean universal coverage. But it would have serious side effects. Among them:

Side Effect #1: Half of all working-age Americans would be dumped into a super-Medicaid program. When faced with a choice between providing a health plan and paying a tax, many employers would opt to end coverage and simply dump their workers into the public program. With the 7 percent payroll tax proposed as the basis for the Mitchell bill, the Washington, D.C.-based Urban Institute estimates that 51.7 million workers would lose their employer-sponsored coverage (one-third of workers who now have company plans).⁶ This would mean 112 million Americans would be in a Medicaid-type program.

Side Effect #2: Americans would face huge tax hikes. If the public program were to be as large as reliable estimates suggest, high payroll or income taxes would be needed to support it. The Urban Institute estimates that with a 7 percent payroll tax, the public program would be underfunded to the tune of \$36.4 billion per year. Even raising the payroll tax to 9 percent would only shave that shortfall to \$25.2 billion. This would leave the government with three choices: 1) operate the system in the red, with the red ink adding tens of billions of dollars to the deficit; 2) raise taxes generally, slowing growth and cutting after-tax incomes; or 3) hike payroll taxes well beyond the level envisioned by the bill's sponsors. But any increase in payroll taxes is a tax on employment and means fewer jobs, especially for the lower-paid.

Side Effect #3: Insurance costs would soar. The cost of health coverage for employers would rise under the Mitchell bill. With a minimum benefits package in the Mitchell bill, the Urban Institute estimates that the extra cost to employers of providing insurance (or paying the tax) would rise by \$29.7 billion, or 23 percent. For large firms, this means an average hike in health costs of 21 percent, and a 71 percent rise for firms with fewer than 25 employees. Moreover, if minimum benefits were mandated by Congress, unions would have the incentive to lobby Congress for across-the-board increases in basic benefits, rather than negotiating with individual firms.

⁶ For an analysis of the Mitchell bill, see Edmund F. Haislmaier, "The Mitchell HealthAmerica Act: A Bait and Switch for American Workers," Heritage Foundation *Issue Bulletin* No. 170, January 17, 1992.

Similarly, medical groups would lobby for certain procedures to be included in the mandatory benefits package (as they have done successfully at the state level). These pressures could increase insurance costs dramatically, leading to more and more workers being shifted into the public program.

Side Effect #4: Small employers would face new hardships. The Mitchell bill does give small firms several years to comply with the play or pay requirement, and it includes various complex tax benefits to offset some of the high cost of small-group insurance and it would delay the mandate to play or pay for four years. But even these breaks add to the complexity of a supposedly simple approach and merely give a four-year breathing space.

Q. Is play or pay an example of “bait and switch”?

A. While purporting to be a simple extension of the current system, play or pay almost certainly would evolve into the government-run system publicly eschewed by its supporters. It baits and then switches.

Reason #1: Employers increasingly would have the incentive to pay rather than play, for the reasons indicated above.

Reason #2: The Mitchell legislation includes draconian anti-discrimination measures against any employer providing insurance who appears to use health condition as a reason not to hire or to lay off an individual (a natural response by employers if they are required by law to cover all families). Faced with the prospect of costly civil rights suits if they provide insurance, it is likely that more and more employers would choose the public option.

Reason #3: Play or pay proposals, including the Mitchell bill, set up all the apparatus needed to introduce a Canadian or British national health system. This includes boards to negotiate fees and set overall budgets—the central feature of the Canadian system. The legislation is replete with references to these boards being “advisory” or offering “recommendations” but few Washington insiders doubt that the board’s decisions soon would be mandatory. Thus Americans might vote for comprehensive employer-provided benefits, but eventually they would find themselves in a super-Medicaid program.

Q. Will Congress suffer from the bait and switch?

A. Absolutely not. Once again, Congress exempts itself. The Mitchell bill would not apply to Congress, the executive and judicial branches, or federal workers.

HOW THE SINGLE-PAYER APPROACH WOULD WORK

The second approach reasons that private markets in health care simply do not work, and that in this one part of the economy the government can do a better job than the private sector. The model used is Canada. By using the government as the central buyer of health care, allocating resources, negotiating fees with physicians and hospitals and cutting out insurance middlemen, advocates of a Canadian-style system for America insist that overhead costs can be slashed, costs kept down, and quality improved. This best of all possible worlds turns out to be snake oil. Among the reasons:

Reason #1: Canada is very different from America.

While the Canadian system satisfies Canadians, it probably would not satisfy Americans or even work in the context of U.S. institutions. For instance:

- ☞ **The political culture is different.** Canadians, like Britons, put a premium on equality, and accept the long waiting lines that come with a system based on rationing (see below). Americans likely would not.
- ☞ **The political institutions are different.** Canada's parliamentary system, with its strong parties, is much less prone to special interest lobbying than the U.S. Congress. That makes it easier for the Canadian government to place strong constraints on doctors and hospitals—and patients. A Canadian system in America also likely would lead to the detailed micro-management by Congress that is seen in Medicare and the Veterans' health program.

Reason #2: There would have to be explicit rationing.

When the government sets an overall budget for health spending, but then declares that care is "free" to all citizens, heavy demand and limited supply lead inevitably to shortage and rationing. This is routine in Canada.

Q. Couldn't there be rationing in the U.S.?

A. No. Under the Canadian system, rationing takes two main forms. First, hospital and other budgets are set by government. And second, doctors routinely make rationing decisions every day—not to save a very premature baby, not to admit immediately a patient with mild chest pains, not to order a CAT scan on a crash victim with a headache. Doctors can do this in Canada because they do not work under the malpractice system facing American doctors. U.S. doctors would find themselves in court if they made rationing decisions like their Canadian counterparts. This means that the doctor-rationing process that is key to the Canadian system would be impossible in the U.S.

To make rationing work, two things would have to occur. First, Congress or the states would have to gut the medical liability laws—no easy political task in face of severe opposition from the trial lawyers and "public interest" groups. Or

second, Congress would have to legislate detailed priority lists for treatments and make no funds available for low-priority treatments—in effect, forcing doctors to ration. The political problem with this, as Oregon is discovering as it tries to introduce priority lists for Medicaid, is that Americans get very angry when treatment for *their* condition is at the bottom of the list. Trying to set national priority lists would be a nightmare for Congress, and would invite constant modification based on lobbying by patient groups and special-interest provider organizations.

Reason #3: The vaunted overhead savings of the Canadian system are highly suspect.

Supporters of the Canadian system say that billions of dollars could be cut out of the overhead in the U.S. system simply by replacing insurance companies with a government monopoly. The argument is that monopoly is efficient in health care, competition inefficient. To be sure, there are indeed great inefficiencies in the U.S. health insurance system, but these are due to perverse consumer incentives and not to deficiencies of competitive markets.

Supporters of the Canadian system tell only half the story. Any health system, like any business, can reduce overhead by eliminating procedures to make sure that resources are used wisely, staff are acting efficiently with an eye on cost, and inventory is kept at economical levels. It can institute budget limits so that the cash simply runs out when too many procedures are performed. But this does not lead to efficiency. On the contrary. In the U.S. health system an enormous amount of paperwork is devoted in health care, as in other parts of the economy, to make sure that health resources are used as efficiently as possible. This certainly generates paperwork but it promotes efficiency and reduces the cost to the economy of keeping patients away from work.

In Canada there are few if any such procedures to promote efficiency. Thus inefficiency is rife in the health system, with hospitals occasionally shutting down for want of key resources, long waiting lists for certain procedures, and outdated equipment in many hospitals. Moreover, when Canadians are waiting for treatment and unable to work, this imposes costs on the Canadian economy.

Reason #4: The Canadian system may be more expensive, not cheaper, than the U.S. system.

Supporters of the Canadian system point to the lower percentage of gross national product spent on health care as proof that the Canadian system is better at controlling costs. But various studies explode this myth.

 **Trend is the same.** If there were savings achieved in the Canadian system, they were made before the system became a national health plan in 1971. Ever since the mid-1970s, however, the rate of increase in costs in Canada has been virtually identical to that in the U.S.

☞ **Creative accounting cuts costs.** One simple reason for the Canadian system appearing less costly is that Canadians do not include many costs in their health spending data that the U.S. does. Example: the construction costs of hospitals are not fully included in Canada's health care spending statistics, while in the U.S. they are. Example: the costs of treating doctors and other health workers are not fully included. If the Canadians employed the same accounting methodology as the U.S., says Jacques Krazny of the international accounting firm of Bogart, Delafield, Ferrier, Inc., based in New Jersey, Canadian health costs would rise by at least 1 percent of GNP.

☞ **Demographic differences.** The Canadian system is not treating the same kind of population. These lifestyle and demographic differences account for cost and quality differences. For example, the teenage pregnancy rate in the U.S. is two-and-a-half times that of Canada and U.S. drug use is higher. This leads to a higher proportion of low birthweight babies. The U.S. population also is older than Canada's. Such differences impose higher costs on the U.S. system, and also explain many of the apparent quality differences suggested by crude infant mortality rates and other national data. There is, moreover, a simple "bottom line" about quality in the U.S. and Canada. It is this: Canadians fly to U.S. when they want the best treatment. Americans do not fly to Canada.

Reason #5: A Canadian system in the U.S. would mean a rapid slide toward central planning.

One stark international lesson of price controls is that they become ever more complicated and pervasive. The Canadians have resorted to increasing regulation to combat the attempts of doctors and patients to "game" the system or avoid controls. To imagine how such a system would work in the U.S. it is unnecessary to go farther than Medicare, which is very similar in design to the Canadian system, with the government setting fees and regulating hospitals and doctors. Every year the regulations grow.

Reason #6: A government-run health system inevitably would be a two-tier system based on money and political connections.

Ordinary Canadians wait patiently in line to be treated. Those with money and political clout do not. When a businessman in Toronto is told his chest pains are not serious enough to warrant immediate treatment, he takes a plane to Buffalo, New York. Trips across the border to get faster and better treatment are routine for Canadians who can afford it. Politicians also do not wait. Either they go to the U.S. or they use their connections to jump the queue.

It is hard to imagine a U.S. senator, or a campaign supporter of the senator, waiting for a bed in a government-run system in the U.S. A bed would be found, as well as the best doctors; others would wait. Or the senator, like others with healthy incomes, would go to wherever he could get private treatment.

HOW A CONSUMER CHOICE SYSTEM WOULD WORK

Under a consumer choice approach, there would be changes in tax law and insurance regulations to empower the consumer to exercise greater control over the health care economy. Essentially, the aim would be to introduce the same market dynamics in health care—with consumers seeking the best value for money and providers competing for the consumer dollar—that work so efficiently in the rest of the economy.

One consumer-based system has been proposed by The Heritage Foundation, and is known as the Heritage Consumer Choice Health Plan.⁷ This will be the subject of Part II of this series of *Talking Points*.

Another, very similar proposal has been advanced by the Washington D.C.-based American Enterprise Institute.⁸ Still another by the Dallas-based National Center for Policy Analysis.⁹ And while the recently announced health reform plan of the Bush Administration is less sweeping than these proposals, it contains some key elements of the consumer choice approach.

While these models do differ significantly in detail, they tend to include similar steps. These are:

☒ **Step #1: Consumers would have the same tax breaks whatever the source of their health plan, not just for employer-based plans.**

By giving the same tax benefits to the purchase of health care insurance whether a plan is obtained by a family through an employer, a union, directly from an insurance company, or from any other source, consumers would be given the opportunity and incentive to “shop around” for the best value and not to overinsure. In addition, employees of small firms would have roughly the same choices as employees of large firms. Some proposals would set up a “health care IRA,” or tax-free savings account, and a family could use this money to buy insurance or to pay for medical services.

☒ **Step #2: More assistance would go to those who need it most to obtain health care.**

Unlike today’s system, in which the biggest tax breaks go to those who have the biggest incomes and the most generous company-sponsored plans, the consumer choice plans would give most help to those who need it most. This generally is accomplished by introducing a refundable tax credit in place of the

7 See footnote 1.

8 Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff, “A Plan for ‘Responsible National Health Insurance,’” *Health Affairs*, Volume 10, No. 1, Spring 1991.

9 *An Agenda for Solving America's Health Care Crisis* (Dallas, Texas: The National Center for Policy Analysis, 1991).

current tax exclusion for company plans. Tax credits do not favor upper-income families, and with a refundable credit the family receives a check from the Treasury if its tax credit exceeds its tax liability—so families too poor to pay much tax also are helped.

☒ **Step #3: Regulations currently thwarting innovative health plans would be ended.**

State mandates on insurance companies, federal and state insurance rules, and federal anti-trust regulations all make it difficult for new types of health plans to emerge to serve the consumer. Consumer choice plans thus include provisions to reduce this red tape, to increase competition among health care providers. Some include federal preemption of state laws, others would make it easier for plans to avoid these or federal rules.

Q. What would a consumer-based system mean for American families?

A. It would mean that families could shop around for the best combination of quality and price in health insurance, just as they do with other insurance purchases, and get the same tax relief wherever they obtained a plan. That would make health insurance like life insurance or mortgage payments, in that tax relief has nothing to do with the place of work.

It would also mean, just as with other forms of insurance, that the family would not lose its coverage just because the policyholder changed jobs or suffered a spell of unemployment. Thus it would solve the main problems faced by Americans families who move or lose their jobs.

Q. Wouldn't families have to become experts in health care?

A. No more than one has to become an engineering expert to buy a car, or an architect to buy a house. In major purchases of this kind, families consult experts to help them make choices, or they choose a product from a trusted organization or seller. The same would be true in health care. Typically families would not choose to bargain with individual doctors over the cost of services, any more than they bargain with auto component manufacturers and have a car built for them. Instead they would choose a comprehensive health plan.

Further, they would normally turn to a trusted plan sponsor or an expert to help them make a decision. A typical family might choose a plan sponsored by their union, or church, or they might simply ask their family doctor or insurance broker to recommend a plan.

Q. How would consumer-based systems control costs?

A. They would do so in the same way that consumer choice achieves cost control in every other major area of the economy: consumers sensitive to price seeking the best value for money.

Q. Is there any evidence that such a plan works?

A. Yes. Large corporations with "cafeteria" plans that include a range of health care options for their employees have seen their costs rise less rapidly. Even more striking, the Federal Employee Health Benefits Program (FEHBP), which covers nearly 10 million federal workers and their families, as well as retirees, gives civil servants a wide range of plans and the financial incentive to choose the best value for money. The result: Over the last decade the rise in costs in the FEHBP has averaged about two percentage points less than in the private sector. During the last three years, the premium increases have averaged about half that of the private sector.¹⁰

CONCLUSION

The debate over health care is one of the most important domestic policy discussions since Congress debated the creation of the Social Security system in the 1930s. The decisions that Congress makes will involve close to one trillion dollars a year in current spending. The pocketbooks of every American will be affected, as will their health.

Reform of the health care system thus must not be the product of election-year posturing and rhetoric. It must be based instead on careful attention to the facts, and there must be reasoned discussion of the causes of today's problems and the merits of rival reform options. If Congress debates health care reform in this way, it will be possible for the U.S. to create a comprehensive health care system that becomes the envy of the world.

¹⁰ Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Background* No. 878, February 6, 1992.

HIGHLIGHTS:

The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package (\$3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups -- so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to \$3,750 in health insurance costs can be deducted by families with incomes less than \$80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

- include governmental price regulation or rationing of health care;
- burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
- require massive tax increases like "play or pay" and national health insurance;
- threaten poor older Americans with benefit reductions or premium increases.

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.¹

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8,500 per year. No employer health insurance is provided:

[Full Credit of \$3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, \$255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State group health plan (or

another private plan) when they no longer qualify for Medicaid.

- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of \$60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of \$3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a \$3,750 tax deduction (a benefit of approximately \$1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermittent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of \$1,250]

- Under the current system, this individual has no access to health insurance, and

¹The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a \$1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of \$50,000, and a \$1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of \$2,750 (\$3,750 minus employer contribution of \$1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

Case #8

A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of \$17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a \$3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance and health care services. Nor are they aware of the hospitals and doctors

included in the plan—or of the relative quality of local hospitals and doctors.

- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.

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THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

February 6, 1992

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM

FACT SHEET

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The President's four-point plan will:

1. Make health care more accessible by making health insurance more affordable;
2. Reduce the runaway costs of health care by making the health care system more efficient;
3. Cut waste and excess in the present system; and
4. Get the growth in government health programs under control.

The President's plan is spelled out in detail in a 94 page white paper released today.

Elements of the President's Plan

The President's plan addresses the two major problems facing the U.S. health care system -- inadequate access to affordable health care for some Americans and excessive growth in the cost of health care for all Americans.

In addressing these problems it enhances the quality of our health care system, widely acknowledged as the best in the world. Moreover, it recognizes and builds upon the strengths of America's health care system: the freedom of individuals to choose physicians, hospitals, and health plans; diversity and

flexibility in the financing, organization and delivery of care; the best educated and most skilled physicians and health professionals in the world; millions of volunteers who assist in providing quality health care; world leadership in biomedical research; dramatic technological innovation and in new methods of assuring quality health care.

I. Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

A transferable health insurance tax credit (certificate) and deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Ninety five million Americans will benefit from these provisions.

Both the credit and deduction would be available for health insurance costs of up to \$1,250 for individuals, \$2,500 for married couples, and \$3,750 for families of three or more. For those with employer-provided health benefits, the credit or deduction would be adjusted for any employer contributions. Individuals could take either the credit or deduction, guided by which is more financially advantageous. The credit and deduction would benefit those with modified adjusted gross income ranging up to:

- \$50,000 for single persons;
- \$65,000 for persons filing as heads of households, and
- \$80,000 for married persons filing jointly.

Both the credit and the deduction would phase out in the last \$10,000 of the income range.

1. Transferable Health Insurance Tax Credits (Certificates)

Transferability. The credit could be transferred only to an insurer for the purchase of health insurance; it could not be used for other purposes or received as cash.

Eligibility. All who do not receive assistance from other federal programs (e.g., covered by Medicare, Medicaid, and other federal health programs) would be eligible.

Income Range. When phased in, the maximum credit would be available to all with incomes of up to 100 percent of the tax filing threshold -- the sum of the standard deduction

and taxpayer and dependent exemptions, a tax code concept that approximates the poverty threshold. Above that level, the credit would phase down to a minimum credit at 150 percent of the tax filing threshold. The minimum credit would be 10 percent of the maximum: \$125 for individuals, \$250 for two person households, and \$375 for households of three and larger.

-- For example, if the credit were in effect today, a family of two parents and two children with adjusted gross income of \$14,000 would obtain the maximum credit, enabling them to buy up to \$3,750 of health insurance.

Risk Adjustment. States would implement broad health risk pools for credit recipients. As a result of transfers carried out by the pool, insurers would be able to provide insurance to the sick and healthy at nearly uniform rates.

Administration. Individuals eligible for the credit would not need to wait until filing a tax return to obtain a credit; a certificate could be obtained at any time during the year by applying to a governmental office designated by a state government. A state might select a state agency, such as the Employment Service, or it might contract with the Social Security Administration to certify eligibility.

2. Deductions

Individuals with incomes up to the top of the income range could choose, instead of the credit, to deduct the cost of health insurance, up to the maximum that applies to their tax filing status (either \$1250, \$2500, or \$3750.) As noted above, the maximum would be adjusted for the amount of employer contributions towards the cost of health insurance.

3. Increased Help for the Self-employed

All of the self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is of greater value. Current law allows the self-employed to deduct only 25 percent of the cost of health insurance.

The cost of the health insurance tax credit and deductions in the President's plan would be offset by savings achieved through use of the measures to contain health care costs outlined below. These include the system efficiencies in the health care delivery system arising from a greater role for market forces, reduced administrative and malpractice costs,

more healthy personal behavior and the effects of preventive services to lessen the need for health services, and greater cost-effectiveness in publicly funded programs. No additional taxes are needed or required.

II. Insurance Market Reform

A. Basic Benefits.

States, working with private insurers, would develop basic health insurance benefit packages equal to the value of the health insurance tax credit. This would enable low-income families to purchase health care coverage.

B. Insurance Security.

Health insurers would be required to insure all groups that want to buy health insurance. Coverage would be guaranteed and renewable. Pre-existing conditions clauses that limit coverage during the first months with a new employer would no longer be allowed.

C. Health Insurance Networks (HINs) - Pooled Purchasing Power.

A new way of purchasing insurance -- HINs -- would enable small firms to purchase low cost, high quality health insurance by reducing administrative costs and by exempting insurance sold through HINs from excessive state premium taxes. HINs would also allow national associations to sell health insurance plans on a nationwide basis.

D. Mandated Benefits.

States have passed numerous laws mandating that health insurance include specified benefits or coverage provisions, now numbering close to 1,000. Excessive mandated benefits that increase costs and limit consumer choice over the scope of insured benefits would no longer be allowed.

E. Insurance Affordability.

In the near term, the premiums insurers charge for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition to deliver the highest quality at the lowest costs.

III. Containing Health Care Costs

A. Malpractice and antitrust reform.

The threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The practice of defensive medicine has contributed substantially to rising health care costs.

The President's plan would provide incentives to states to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care.

New procedural reforms would promote alternative dispute resolution (ADR). A party that refused ADR and then lost the suit at trial would pay the other party its attorney fees.

Also, the potential of guidelines and standards of care to reduce the uncertainty that leads to defensive medicine will be explored.

Fear of antitrust liability has also helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Quality of care is diminished by the reluctance of professional review boards and hospitals to discipline physicians. Finally, the emergence of new, more competitive systems for delivering health care has raised new questions about the application of the antitrust laws to the health care system.

The President's proposal will provide additional guidance on the application of the antitrust laws in these areas and provide a "safe harbor" for certain joint activities relating to the sharing of equipment by providers.

B. Reducing administrative costs.

Insurance law changes and market reforms will end the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs.

For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased,

compared to 10 percent for large employers. Marketing and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of administering insurance and therefore help substantially reduce premiums. Small businesses would benefit from these efficiencies. HINs would follow uniform claims processing standards, yielding additional administrative savings.

C. Expanded use of coordinated care.

In 1990, about 40 million Americans were enrolled in one of a variety of coordinated care arrangements -- up from 10 million in 1980. The President's plan encourages broader use of coordinated care in the public and private sectors, including preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point of service plans that allow individuals to choose between the PPO and HMO option, case management, and other forms of coordinated care.

New coordinated care arrangements would be allowed in the Medicare program. States would have incentives to use coordinated care in Medicaid programs. Restrictions on the operation of coordinated care in the private sector would be ended.

D. Efficiencies in public programs.

Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and reforms to stem program abuses.

E. Increased flexibility in state programs.

States would be free to redesign their entire health care systems. The acute care portion of the Medicaid program, covering hospital and doctor services, would be restructured, moving from an open ended entitlement to a per capita payment arrangement. With this change, current federal restrictions on the use of coordinated care and review processes for waiver requests would be dropped.

With respect to the relationship of Medicaid to the new transferable health insurance tax credit, states could choose to combine current Medicaid funding with the new

credit to develop a single unified health plan for low-income persons.

F. Expansion of cost-effective services in underserved areas.

The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand primary and preventive care in these areas.

G. Prevention.

The President's budget includes \$26.4 billion, a nearly \$4 billion (18 percent) increase for preventive health activities. Prevention funding has increased over \$11 billion (74 percent) since 1989. Among other activities, the President's FY 1993 budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

H. Improving Consumer Information.

While health care services can be costly, information about the cost and quality of providers is not readily available. To assist individuals and employers shopping for insurance and health care, "blue books" like guides for other goods and services would provide price and quality data to make comparison shopping possible. The information will cover the average cost of services and the quality of care provided by physicians, hospitals, and clinical laboratories.

The white paper on the President's Comprehensive Health Reform Program also presents an analysis of two of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax.

The paper concludes with examples showing the President's plan at work in the context of these examples.

HIGHLIGHTS:

The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package (\$3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups -- so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to \$3,750 in health insurance costs can be deducted by families with incomes less than \$80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

- include governmental price regulation or rationing of health care;
- burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
- require massive tax increases like "play or pay" and national health insurance;
- threaten poor older Americans with benefit reductions or premium increases.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

February 6, 1992

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The paper concludes with examples showing the President's plan at work in the context of these examples.

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.¹

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8,500 per year. No employer health insurance is provided:

[Full Credit of \$3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, \$255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State group health plan (or

another private plan) when they no longer qualify for Medicaid.

- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of \$60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of \$3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a \$3,750 tax deduction (a benefit of approximately \$1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermittent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of \$1,250]

- Under the current system, this individual has no access to health insurance, and

¹The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a \$1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of \$50,000, and a \$1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of \$2,750 (\$3,750 minus employer contribution of \$1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
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An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

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- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
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Case #8

A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of \$17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a \$3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance and health care services. Nor are they aware of the hospitals and doctors

included in the plan—or of the relative quality of local hospitals and doctors.

- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.

HIGHLIGHTS:

The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package (\$3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups -- so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to \$3,750 in health insurance costs can be deducted by families with incomes less than \$80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

- include governmental price regulation or rationing of health care;
- burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
- require massive tax increases like "play or pay" and national health insurance;
- threaten poor older Americans with benefit reductions or premium increases.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

February 6, 1992

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM
FACT SHEET

The President today announced his four point plan for comprehensive reform of the Nation's health care system. Following the outline the President offered in his State of the Union Address, the plan seeks to use market forces and incentives to forge a more efficient health care system.

The President's four-point plan will:

1. Make health care more accessible by making health insurance more affordable;
2. Reduce the runaway costs of health care by making the health care system more efficient;
3. Cut waste and excess in the present system; and
4. Get the growth in government health programs under control.

The President's plan is spelled out in detail in a 94 page white paper released today.

Elements of the President's Plan

The President's plan addresses the two major problems facing the U.S. health care system -- inadequate access to affordable health care for some Americans and excessive growth in the cost of health care for all Americans.

In addressing these problems it enhances the quality of our health care system, widely acknowledged as the best in the world. Moreover, it recognizes and builds upon the strengths of America's health care system: the freedom of individuals to choose physicians, hospitals, and health plans; diversity and

flexibility in the financing, organization and delivery of care; the best educated and most skilled physicians and health professionals in the world; millions of volunteers who assist in providing quality health care; world leadership in biomedical research; dramatic technological innovation and in new methods of assuring quality health care.

I. Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

A transferable health insurance tax credit (certificate) and deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Ninety five million Americans will benefit from these provisions.

Both the credit and deduction would be available for health insurance costs of up to \$1,250 for individuals, \$2,500 for married couples, and \$3,750 for families of three or more. For those with employer-provided health benefits, the credit or deduction would be adjusted for any employer contributions. Individuals could take either the credit or deduction, guided by which is more financially advantageous. The credit and deduction would benefit those with modified adjusted gross income ranging up to:

- \$50,000 for single persons;
- \$65,000 for persons filing as heads of households, and
- \$80,000 for married persons filing jointly.

Both the credit and the deduction would phase out in the last \$10,000 of the income range.

1. Transferable Health Insurance Tax Credits (Certificates)

Transferability. The credit could be transferred only to an insurer for the purchase of health insurance; it could not be used for other purposes or received as cash.

Eligibility. All who do not receive assistance from other federal programs (e.g., covered by Medicare, Medicaid, and other federal health programs) would be eligible.

Income Range. When phased in, the maximum credit would be available to all with incomes of up to 100 percent of the tax filing threshold -- the sum of the standard deduction

and taxpayer and dependent exemptions, a tax code concept that approximates the poverty threshold. Above that level, the credit would phase down to a minimum credit at 150 percent of the tax filing threshold. The minimum credit would be 10 percent of the maximum: \$125 for individuals, \$250 for two person households, and \$375 for households of three and larger.

-- For example, if the credit were in effect today, a family of two parents and two children with adjusted gross income of \$14,000 would obtain the maximum credit, enabling them to buy up to \$3,750 of health insurance.

Risk Adjustment. States would implement broad health risk pools for credit recipients. As a result of transfers carried out by the pool, insurers would be able to provide insurance to the sick and healthy at nearly uniform rates.

Administration. Individuals eligible for the credit would not need to wait until filing a tax return to obtain a credit; a certificate could be obtained at any time during the year by applying to a governmental office designated by a state government. A state might select a state agency, such as the Employment Service, or it might contract with the Social Security Administration to certify eligibility.

2. Deductions

Individuals with incomes up to the top of the income range could choose, instead of the credit, to deduct the cost of health insurance, up to the maximum that applies to their tax filing status (either \$1250, \$2500, or \$3750.) As noted above, the maximum would be adjusted for the amount of employer contributions towards the cost of health insurance.

3. Increased Help for the Self-employed

All of the self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is of greater value. Current law allows the self-employed to deduct only 25 percent of the cost of health insurance.

The cost of the health insurance tax credit and deductions in the President's plan would be offset by savings achieved through use of the measures to contain health care costs outlined below. These include the system efficiencies in the health care delivery system arising from a greater role for market forces, reduced administrative and malpractice costs,

more healthy personal behavior and the effects of preventive services to lessen the need for health services, and greater cost-effectiveness in publicly funded programs. No additional taxes are needed or required.

II. Insurance Market Reform

A. Basic Benefits.

States, working with private insurers, would develop basic health insurance benefit packages equal to the value of the health insurance tax credit. This would enable low-income families to purchase health care coverage.

B. Insurance Security.

Health insurers would be required to insure all groups that want to buy health insurance. Coverage would be guaranteed and renewable. Pre-existing conditions clauses that limit coverage during the first months with a new employer would no longer be allowed.

C. Health Insurance Networks (HINs) - Pooled Purchasing Power.

A new way of purchasing insurance -- HINs -- would enable small firms to purchase low cost, high quality health insurance by reducing administrative costs and by exempting insurance sold through HINs from excessive state premium taxes. HINs would also allow national associations to sell health insurance plans on a nationwide basis.

D. Mandated Benefits.

States have passed numerous laws mandating that health insurance include specified benefits or coverage provisions, now numbering close to 1,000. Excessive mandated benefits that increase costs and limit consumer choice over the scope of insured benefits would no longer be allowed.

E. Insurance Affordability.

In the near term, the premiums insurers charge for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition to deliver the highest quality at the lowest costs.

III. Containing Health Care Costs

A. Malpractice and antitrust reform.

The threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The practice of defensive medicine has contributed substantially to rising health care costs.

The President's plan would provide incentives to states to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care.

New procedural reforms would promote alternative dispute resolution (ADR). A party that refused ADR and then lost the suit at trial would pay the other party its attorney fees.

Also, the potential of guidelines and standards of care to reduce the uncertainty that leads to defensive medicine will be explored.

Fear of antitrust liability has also helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Quality of care is diminished by the reluctance of professional review boards and hospitals to discipline physicians. Finally, the emergence of new, more competitive systems for delivering health care has raised new questions about the application of the antitrust laws to the health care system.

The President's proposal will provide additional guidance on the application of the antitrust laws in these areas and provide a "safe harbor" for certain joint activities relating to the sharing of equipment by providers.

B. Reducing administrative costs.

Insurance law changes and market reforms will end the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs.

For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased,

compared to 10 percent for large employers. Marketing and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of administering insurance and therefore help substantially reduce premiums. Small businesses would benefit from these efficiencies. HINs would follow uniform claims processing standards, yielding additional administrative savings.

C. Expanded use of coordinated care.

In 1990, about 40 million Americans were enrolled in one of a variety of coordinated care arrangements -- up from 10 million in 1980. The President's plan encourages broader use of coordinated care in the public and private sectors, including preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point of service plans that allow individuals to choose between the PPO and HMO option, case management, and other forms of coordinated care.

New coordinated care arrangements would be allowed in the Medicare program. States would have incentives to use coordinated care in Medicaid programs. Restrictions on the operation of coordinated care in the private sector would be ended.

D. Efficiencies in public programs.

Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and reforms to stem program abuses.

E. Increased flexibility in state programs.

States would be free to redesign their entire health care systems. The acute care portion of the Medicaid program, covering hospital and doctor services, would be restructured, moving from an open ended entitlement to a per capita payment arrangement. With this change, current federal restrictions on the use of coordinated care and review processes for waiver requests would be dropped.

With respect to the relationship of Medicaid to the new transferable health insurance tax credit, states could choose to combine current Medicaid funding with the new

credit to develop a single unified health plan for low-income persons.

F. Expansion of cost-effective services in underserved areas.

The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand primary and preventive care in these areas.

G. Prevention.

The President's budget includes \$26.4 billion, a nearly \$4 billion (18 percent) increase for preventive health activities. Prevention funding has increased over \$11 billion (74 percent) since 1989. Among other activities, the President's FY 1993 budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

H. Improving Consumer Information.

While health care services can be costly, information about the cost and quality of providers is not readily available. To assist individuals and employers shopping for insurance and health care, "blue books" like guides for other goods and services would provide price and quality data to make comparison shopping possible. The information will cover the average cost of services and the quality of care provided by physicians, hospitals, and clinical laboratories.

The white paper on the President's Comprehensive Health Reform Program also presents an analysis of two of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax.

The paper concludes with examples showing the President's plan at work in the context of these examples.

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.¹

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8,500 per year. No employer health insurance is provided:

[Full Credit of \$3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, \$255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State group health plan (or

another private plan) when they no longer qualify for Medicaid.

- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of \$60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of \$3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a \$3,750 tax deduction (a benefit of approximately \$1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermittent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of \$1,250]

- Under the current system, this individual has no access to health insurance, and

¹ The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a \$1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of \$50,000, and a \$1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of \$2,750 (\$3,750 minus employer contribution of \$1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

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New coordinated care arrangements would be allowed in the Medicare program. States would have incentives to use coordinated care in Medicaid programs. Restrictions on the operation of coordinated care in the private sector would be ended.

D. Efficiencies in public programs.

Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and reforms to stem program abuses.

E. Increased flexibility in state programs.

States would be free to redesign their entire health care systems. The acute care portion of the Medicaid program, covering hospital and doctor services, would be restructured, moving from an open ended entitlement to a per capita payment arrangement. With this change, current federal restrictions on the use of coordinated care and review processes for waiver requests would be dropped.

With respect to the relationship of Medicaid to the new transferable health insurance tax credit, states could choose to combine current Medicaid funding with the new

credit to develop a single unified health plan for low-income persons.

F. Expansion of cost-effective services in underserved areas.

The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand primary and preventive care in these areas.

G. Prevention.

The President's budget includes \$26.4 billion, a nearly \$4 billion (18 percent) increase for preventive health activities. Prevention funding has increased over \$11 billion (74 percent) since 1989. Among other activities, the President's FY 1993 budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

H. Improving Consumer Information.

While health care services can be costly, information about the cost and quality of providers is not readily available. To assist individuals and employers shopping for insurance and health care, "blue books" like guides for other goods and services would provide price and quality data to make comparison shopping possible. The information will cover the average cost of services and the quality of care provided by physicians, hospitals, and clinical laboratories.

The white paper on the President's Comprehensive Health Reform Program also presents an analysis of two of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax.

The paper concludes with examples showing the President's plan at work in the context of these examples.

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.¹

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8,500 per year. No employer health insurance is provided:

[Full Credit of \$3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, \$255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State group health plan (or

another private plan) when they no longer qualify for Medicaid.

- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of \$60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of \$3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a \$3,750 tax deduction (a benefit of approximately \$1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermittent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of \$1,250]

- Under the current system, this individual has no access to health insurance, and

¹The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a \$1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of \$50,000, and a \$1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of \$2,750 (\$3,750 minus employer contribution of \$1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

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A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of \$17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a \$3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance and health care services. Nor are they aware of the hospitals and doctors

included in the plan—or of the relative quality of local hospitals and doctors.

- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.



OFFICE OF THE VICE PRESIDENT
WASHINGTON

February 6, 1992

Dr. Adrian Graff-Radford
40-380 Desert Creek Lane
Rancho Mirage, California 92270

Dear Dr. Graff-Radford:

I thought you might be interested in the attached materials describing the Administration's health proposals. This package should address the problem of access without setting up a system that would undermine the quality of care.

All the best.

Sincerely,

Richard W. Porter
Counselor to the Vice President

Attachments

Extra copies
of Bush health
plan -
Please file
in Health Care
File



OFFICE OF THE VICE PRESIDENT
WASHINGTON

February 6, 1992

Dr. Wayne E. Kuhl
3600 North Third Avenue
Phoenix, Arizona 85013

Dear Dr. Kuhl:

I enjoyed meeting you at the delightful dinner the Herberger's hosted on behalf of the Vice President. I know he enjoyed seeing old friends and making new ones.

As we discussed, I'm enclosing materials describing the Administration's health proposals. The plan includes many components of the 10 point plan we discussed over coffee. We would be interested in any comments you might have on it.

Again, it was a pleasure meeting you.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard W. Porter".

Richard W. Porter
Counselor to the Vice President

Enclosures



OFFICE OF THE VICE PRESIDENT
WASHINGTON

February 6, 1992

Dr. Robert Murphy
3 Vista Santa Rosa
Rancho Mirage, California 92270

Dear Dr. Murphy:

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Richard W. Porter
Counselor to the Vice President

Attachments



OFFICE OF THE VICE PRESIDENT
WASHINGTON

February 6, 1992

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10-315 Cholla Lane
Rancho Mirage, California 92270

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Attachments

health
plan

Document Originally
Attached to
Following Page

HIGHLIGHTS:

The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package (\$3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups -- so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to \$3,750 in health insurance costs can be deducted by families with incomes less than \$80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

- include governmental price regulation or rationing of health care;
- burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
- require massive tax increases like "play or pay" and national health insurance;
- threaten poor older Americans with benefit reductions or premium increases.

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

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THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

February 6, 1992

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM
FACT SHEET

The President today announced his four point plan for comprehensive reform of the Nation's health care system. Following the outline the President offered in his State of the Union Address, the plan seeks to use market forces and incentives to forge a more efficient health care system.

The President's four-point plan will:

1. Make health care more accessible by making health insurance more affordable;
2. Reduce the runaway costs of health care by making the health care system more efficient;
3. Cut waste and excess in the present system; and
4. Get the growth in government health programs under control.

The President's plan is spelled out in detail in a 94 page white paper released today.

Elements of the President's Plan

The President's plan addresses the two major problems facing the U.S. health care system -- inadequate access to affordable health care for some Americans and excessive growth in the cost of health care for all Americans.

In addressing these problems it enhances the quality of our health care system, widely acknowledged as the best in the world. Moreover, it recognizes and builds upon the strengths of America's health care system: the freedom of individuals to choose physicians, hospitals, and health plans; diversity and

flexibility in the financing, organization and delivery of care; the best educated and most skilled physicians and health professionals in the world; millions of volunteers who assist in providing quality health care; world leadership in biomedical research; dramatic technological innovation and in new methods of assuring quality health care.

I. Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

A transferable health insurance tax credit (certificate) and deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Ninety five million Americans will benefit from these provisions.

Both the credit and deduction would be available for health insurance costs of up to \$1,250 for individuals, \$2,500 for married couples, and \$3,750 for families of three or more. For those with employer-provided health benefits, the credit or deduction would be adjusted for any employer contributions. Individuals could take either the credit or deduction, guided by which is more financially advantageous. The credit and deduction would benefit those with modified adjusted gross income ranging up to:

- \$50,000 for single persons;
- \$65,000 for persons filing as heads of households, and
- \$80,000 for married persons filing jointly.

Both the credit and the deduction would phase out in the last \$10,000 of the income range.

1. Transferable Health Insurance Tax Credits (Certificates)

Transferability. The credit could be transferred only to an insurer for the purchase of health insurance; it could not be used for other purposes or received as cash.

Eligibility. All who do not receive assistance from other federal programs (e.g., covered by Medicare, Medicaid, and other federal health programs) would be eligible.

Income Range. When phased in, the maximum credit would be available to all with incomes of up to 100 percent of the tax filing threshold -- the sum of the standard deduction

and taxpayer and dependent exemptions, a tax code concept that approximates the poverty threshold. Above that level, the credit would phase down to a minimum credit at 150 percent of the tax filing threshold. The minimum credit would be 10 percent of the maximum: \$125 for individuals, \$250 for two person households, and \$375 for households of three and larger.

-- For example, if the credit were in effect today, a family of two parents and two children with adjusted gross income of \$14,000 would obtain the maximum credit, enabling them to buy up to \$3,750 of health insurance.

Risk Adjustment. States would implement broad health risk pools for credit recipients. As a result of transfers carried out by the pool, insurers would be able to provide insurance to the sick and healthy at nearly uniform rates.

Administration. Individuals eligible for the credit would not need to wait until filing a tax return to obtain a credit; a certificate could be obtained at any time during the year by applying to a governmental office designated by a state government. A state might select a state agency, such as the Employment Service, or it might contract with the Social Security Administration to certify eligibility.

2. Deductions

Individuals with incomes up to the top of the income range could choose, instead of the credit, to deduct the cost of health insurance, up to the maximum that applies to their tax filing status (either \$1250, \$2500, or \$3750.) As noted above, the maximum would be adjusted for the amount of employer contributions towards the cost of health insurance.

3. Increased Help for the Self-employed

All of the self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is of greater value. Current law allows the self-employed to deduct only 25 percent of the cost of health insurance.

The cost of the health insurance tax credit and deductions in the President's plan would be offset by savings achieved through use of the measures to contain health care costs outlined below. These include the system efficiencies in the health care delivery system arising from a greater role for market forces, reduced administrative and malpractice costs,

more healthy personal behavior and the effects of preventive services to lessen the need for health services, and greater cost-effectiveness in publicly funded programs. No additional taxes are needed or required.

II. Insurance Market Reform

A. Basic Benefits.

States, working with private insurers, would develop basic health insurance benefit packages equal to the value of the health insurance tax credit. This would enable low-income families to purchase health care coverage.

B. Insurance Security.

Health insurers would be required to insure all groups that want to buy health insurance. Coverage would be guaranteed and renewable. Pre-existing conditions clauses that limit coverage during the first months with a new employer would no longer be allowed.

C. Health Insurance Networks (HINs) - Pooled Purchasing Power.

A new way of purchasing insurance -- HINs -- would enable small firms to purchase low cost, high quality health insurance by reducing administrative costs and by exempting insurance sold through HINs from excessive state premium taxes. HINs would also allow national associations to sell health insurance plans on a nationwide basis.

D. Mandated Benefits.

States have passed numerous laws mandating that health insurance include specified benefits or coverage provisions, now numbering close to 1,000. Excessive mandated benefits that increase costs and limit consumer choice over the scope of insured benefits would no longer be allowed.

E. Insurance Affordability.

In the near term, the premiums insurers charge for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition to deliver the highest quality at the lowest costs.

III. Containing Health Care Costs

A. Malpractice and antitrust reform.

The threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The practice of defensive medicine has contributed substantially to rising health care costs.

The President's plan would provide incentives to states to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care.

New procedural reforms would promote alternative dispute resolution (ADR). A party that refused ADR and then lost the suit at trial would pay the other party its attorney fees.

Also, the potential of guidelines and standards of care to reduce the uncertainty that leads to defensive medicine will be explored.

Fear of antitrust liability has also helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Quality of care is diminished by the reluctance of professional review boards and hospitals to discipline physicians. Finally, the emergence of new, more competitive systems for delivering health care has raised new questions about the application of the antitrust laws to the health care system.

The President's proposal will provide additional guidance on the application of the antitrust laws in these areas and provide a "safe harbor" for certain joint activities relating to the sharing of equipment by providers.

B. Reducing administrative costs.

Insurance law changes and market reforms will end the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs.

For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased,

compared to 10 percent for large employers. Marketing and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of administering insurance and therefore help substantially reduce premiums. Small businesses would benefit from these efficiencies. HINs would follow uniform claims processing standards, yielding additional administrative savings.

C. Expanded use of coordinated care.

In 1990, about 40 million Americans were enrolled in one of a variety of coordinated care arrangements -- up from 10 million in 1980. The President's plan encourages broader use of coordinated care in the public and private sectors, including preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point of service plans that allow individuals to choose between the PPO and HMO option, case management, and other forms of coordinated care.

New coordinated care arrangements would be allowed in the Medicare program. States would have incentives to use coordinated care in Medicaid programs. Restrictions on the operation of coordinated care in the private sector would be ended.

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Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and reforms to stem program abuses.

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The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand primary and preventive care in these areas.

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The white paper on the President's Comprehensive Health Reform Program also presents an analysis of two of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax.

The paper concludes with examples showing the President's plan at work in the context of these examples.

HIGHLIGHTS:

The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

- **The President's plan guarantees access to health insurance for *all* poor families** through a transferable health insurance tax credit (certificate) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package (\$3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
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- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.
- **The President's plan will use the power of an informed marketplace to help control costs** by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.
- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

- include governmental price regulation or rationing of health care;
- burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
- require massive tax increases like "play or pay" and national health insurance;
- threaten poor older Americans with benefit reductions or premium increases.

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.¹

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8,500 per year. No employer health insurance is provided:

[Full Credit of \$3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, \$255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State group health plan (or

another private plan) when they no longer qualify for Medicaid.

- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of \$60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of \$3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a \$3,750 tax deduction (a benefit of approximately \$1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermittent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of \$1,250]

- Under the current system, this individual has no access to health insurance, and

¹The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a \$1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of \$50,000, and a \$1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of \$2,750 (\$3,750 minus employer contribution of \$1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

Case #8

A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of \$17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a \$3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance and health care services. Nor are they aware of the hospitals and doctors included in the plan—or of the relative quality of local hospitals and doctors.
- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

February 6, 1992

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM

FACT SHEET

The President today announced his four point plan for comprehensive reform of the Nation's health care system. Following the outline the President offered in his State of the Union Address, the plan seeks to use market forces and incentives to forge a more efficient health care system.

The President's four-point plan will:

1. Make health care more accessible by making health insurance more affordable;
2. Reduce the runaway costs of health care by making the health care system more efficient;
3. Cut waste and excess in the present system; and
4. Get the growth in government health programs under control.

The President's plan is spelled out in detail in a 94 page white paper released today.

Elements of the President's Plan

The President's plan addresses the two major problems facing the U.S. health care system -- inadequate access to affordable health care for some Americans and excessive growth in the cost of health care for all Americans.

In addressing these problems it enhances the quality of our health care system, widely acknowledged as the best in the world. Moreover, it recognizes and builds upon the strengths of America's health care system: the freedom of individuals to choose physicians, hospitals, and health plans; diversity and

flexibility in the financing, organization and delivery of care; the best educated and most skilled physicians and health professionals in the world; millions of volunteers who assist in providing quality health care; world leadership in biomedical research; dramatic technological innovation and in new methods of assuring quality health care.

I. Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

A transferable health insurance tax credit (certificate) and deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Ninety five million Americans will benefit from these provisions.

Both the credit and deduction would be available for health insurance costs of up to \$1,250 for individuals, \$2,500 for married couples, and \$3,750 for families of three or more. For those with employer-provided health benefits, the credit or deduction would be adjusted for any employer contributions. Individuals could take either the credit or deduction, guided by which is more financially advantageous. The credit and deduction would benefit those with modified adjusted gross income ranging up to:

- \$50,000 for single persons;
- \$65,000 for persons filing as heads of households, and
- \$80,000 for married persons filing jointly.

Both the credit and the deduction would phase out in the last \$10,000 of the income range.

1. Transferable Health Insurance Tax Credits (Certificates)

Transferability. The credit could be transferred only to an insurer for the purchase of health insurance; it could not be used for other purposes or received as cash.

Eligibility. All who do not receive assistance from other federal programs (e.g., covered by Medicare, Medicaid, and other federal health programs) would be eligible.

Income Range. When phased in, the maximum credit would be available to all with incomes of up to 100 percent of the tax filing threshold -- the sum of the standard deduction

and taxpayer and dependent exemptions, a tax code concept that approximates the poverty threshold. Above that level, the credit would phase down to a minimum credit at 150 percent of the tax filing threshold. The minimum credit would be 10 percent of the maximum: \$125 for individuals, \$250 for two person households, and \$375 for households of three and larger.

-- For example, if the credit were in effect today, a family of two parents and two children with adjusted gross income of \$14,000 would obtain the maximum credit, enabling them to buy up to \$3,750 of health insurance.

Risk Adjustment. States would implement broad health risk pools for credit recipients. As a result of transfers carried out by the pool, insurers would be able to provide insurance to the sick and healthy at nearly uniform rates.

Administration. Individuals eligible for the credit would not need to wait until filing a tax return to obtain a credit; a certificate could be obtained at any time during the year by applying to a governmental office designated by a state government. A state might select a state agency, such as the Employment Service, or it might contract with the Social Security Administration to certify eligibility.

2. Deductions

Individuals with incomes up to the top of the income range could choose, instead of the credit, to deduct the cost of health insurance, up to the maximum that applies to their tax filing status (either \$1250, \$2500, or \$3750.) As noted above, the maximum would be adjusted for the amount of employer contributions towards the cost of health insurance.

3. Increased Help for the Self-employed

All of the self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is of greater value. Current law allows the self-employed to deduct only 25 percent of the cost of health insurance.

The cost of the health insurance tax credit and deductions in the President's plan would be offset by savings achieved through use of the measures to contain health care costs outlined below. These include the system efficiencies in the health care delivery system arising from a greater role for market forces, reduced administrative and malpractice costs,

more healthy personal behavior and the effects of preventive services to lessen the need for health services, and greater cost-effectiveness in publicly funded programs. No additional taxes are needed or required.

II. Insurance Market Reform

A. Basic Benefits.

States, working with private insurers, would develop basic health insurance benefit packages equal to the value of the health insurance tax credit. This would enable low-income families to purchase health care coverage.

B. Insurance Security.

Health insurers would be required to insure all groups that want to buy health insurance. Coverage would be guaranteed and renewable. Pre-existing conditions clauses that limit coverage during the first months with a new employer would no longer be allowed.

C. Health Insurance Networks (HINs) - Pooled Purchasing Power.

A new way of purchasing insurance -- HINs -- would enable small firms to purchase low cost, high quality health insurance by reducing administrative costs and by exempting insurance sold through HINs from excessive state premium taxes. HINs would also allow national associations to sell health insurance plans on a nationwide basis.

D. Mandated Benefits.

States have passed numerous laws mandating that health insurance include specified benefits or coverage provisions, now numbering close to 1,000. Excessive mandated benefits that increase costs and limit consumer choice over the scope of insured benefits would no longer be allowed.

E. Insurance Affordability.

In the near term, the premiums insurers charge for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition to deliver the highest quality at the lowest costs.

III. Containing Health Care Costs

A. Malpractice and antitrust reform.

The threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The practice of defensive medicine has contributed substantially to rising health care costs.

The President's plan would provide incentives to states to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care.

New procedural reforms would promote alternative dispute resolution (ADR). A party that refused ADR and then lost the suit at trial would pay the other party its attorney fees.

Also, the potential of guidelines and standards of care to reduce the uncertainty that leads to defensive medicine will be explored.

Fear of antitrust liability has also helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Quality of care is diminished by the reluctance of professional review boards and hospitals to discipline physicians. Finally, the emergence of new, more competitive systems for delivering health care has raised new questions about the application of the antitrust laws to the health care system.

The President's proposal will provide additional guidance on the application of the antitrust laws in these areas and provide a "safe harbor" for certain joint activities relating to the sharing of equipment by providers.

B. Reducing administrative costs.

Insurance law changes and market reforms will end the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs.

For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased,

compared to 10 percent for large employers. Marketing and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of administering insurance and therefore help substantially reduce premiums. Small businesses would benefit from these efficiencies. HINs would follow uniform claims processing standards, yielding additional administrative savings.

C. Expanded use of coordinated care.

In 1990, about 40 million Americans were enrolled in one of a variety of coordinated care arrangements -- up from 10 million in 1980. The President's plan encourages broader use of coordinated care in the public and private sectors, including preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point of service plans that allow individuals to choose between the PPO and HMO option, case management, and other forms of coordinated care.

New coordinated care arrangements would be allowed in the Medicare program. States would have incentives to use coordinated care in Medicaid programs. Restrictions on the operation of coordinated care in the private sector would be ended.

D. Efficiencies in public programs.

Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and reforms to stem program abuses.

E. Increased flexibility in state programs.

States would be free to redesign their entire health care systems. The acute care portion of the Medicaid program, covering hospital and doctor services, would be restructured, moving from an open ended entitlement to a per capita payment arrangement. With this change, current federal restrictions on the use of coordinated care and review processes for waiver requests would be dropped.

With respect to the relationship of Medicaid to the new transferable health insurance tax credit, states could choose to combine current Medicaid funding with the new

credit to develop a single unified health plan for low-income persons.

F. Expansion of cost-effective services in underserved areas.

The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand primary and preventive care in these areas.

G. Prevention.

The President's budget includes \$26.4 billion, a nearly \$4 billion (18 percent) increase for preventive health activities. Prevention funding has increased over \$11 billion (74 percent) since 1989. Among other activities, the President's FY 1993 budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

H. Improving Consumer Information.

While health care services can be costly, information about the cost and quality of providers is not readily available. To assist individuals and employers shopping for insurance and health care, "blue books" like guides for other goods and services would provide price and quality data to make comparison shopping possible. The information will cover the average cost of services and the quality of care provided by physicians, hospitals, and clinical laboratories.

The white paper on the President's Comprehensive Health Reform Program also presents an analysis of two of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax.

The paper concludes with examples showing the President's plan at work in the context of these examples.