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# *Mrs. Clinton Has Entered the Race*

## *The 2004 Democratic Presidential Candidates' Proposals to Reform Health Insurance*

by Michael F. Cannon

## Executive Summary

In 1992 Gov. Bill Clinton of Arkansas unseated incumbent President George H. W. Bush in part by tapping voter dissatisfaction with the rising cost of health insurance and the growing number of Americans without health insurance. Despite a massive legislative campaign directed by then–first lady Hillary Rodham Clinton, the Clinton administration's sweeping proposal to increase federal control over the health care sector languished and eventually died in Congress. Today, with health insurance costs once again rising at double-digit rates and the number of uninsured Americans at a new high, the Democratic candidates for president have lined up their own health insurance reform proposals. The major candidates are Army Gen. Wesley Clark (ret.), former governor of Vermont Howard Dean, Sen. John Edwards (NC), Sen. John Kerry (MA), Rep. Dennis Kucinich (OH), Sen. Joe Lieberman (CT), and Rev. Al Sharpton. Before leaving the race, Rep. Richard Gephardt (MO) also put forward a major health care proposal.

Unfortunately, the candidates' health plans reflect the same misconceptions as and rely on approaches similar to those of the failed Clinton health plan. Like the Clinton health plan, they misdiagnose what ails the health care sector; would attempt to direct the provision of health care from Washington, DC, through increased taxes, government spending, and bureaucratic control; and would magnify the perverse incentives created by past government interventions. Like that of the Clinton health plan, their response to the use of unconstitutional government power in the health care sector is to wield even more unconstitutional power.

The five major candidates (Clark, Dean, Edwards, Kerry, and Lieberman) would take incremental steps toward a government-run health care system. The two long-shot candidates in the race (Kucinich and Sharpton) take a more aggressive approach, calling for an immediate government takeover. Although Sen. Hillary Rodham Clinton (D-NY) disappointed many Democratic Party faithful by forgoing a race for president this year, judging by the health care proposals of the current field, her influence is being clearly felt.

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## Introduction

Americans endure rising health care costs, diminished access to health care, and high levels of frustration as a direct result of health insurance being among the most government-dominated sectors of the U.S. economy. Instead of a market where health care providers and patients benefit each other and society by pursuing their self-interest, government involvement in health insurance markets has given America a system that substitutes waste for economy, rising prices for affordability, and bureaucratic dictates for consumer choice.

In a free market, consumers and producers make voluntary exchanges that benefit both parties. In a genuinely free market, consumers motivated by their own self-interest will naturally make decisions that reward the most efficient producers, while punishing inefficiency and high prices. As a result, producers search for less costly ways of meeting consumer needs. In that environment, prices convey information. They signal to consumers the cost to society of providing various products at different points in time. To producers, prices convey information about what consumers want, helping them identify activities useful to consumers and avoid unwanted activities. Over time, this process makes an ever-increasing number of products, of ever-increasing quality, available to an ever-larger number of consumers.

In America's health care sector, government blocks the market process by hiding prices from patients, thus encouraging patients to consume more care and demand less value. This denies patients information on how their actions affect others, a necessary component of controlling costs and eliminating waste. At the same time, it denies producers information about what consumers value most. Rather than let producers be guided by prices that reflect consumer preferences, government distorts prices or sets them arbitrarily. This encourages producers to pursue lawmakers' preferences instead of consumers'—and to lobby for prices that reflect their own preferences. Denied the necessary information, consumers and producers are less able and willing to circumvent waste, inefficiency, and high prices. Controlling health care costs and improving patient satisfaction require reforms that bring consumers' preferences to the fore by removing government's preferences—by deregulating health insurance and restoring incentives for patients to demand value.

The health plan proposed by President Clinton in 1993 would have taken America in the opposite direction. Government would have encouraged patients to consume more medical care and demand even less value, sending more distorted signals to producers through greater use of price controls. The information necessary to promote health care quality and eliminate waste would have been even more severely restricted.

Although the details of their proposals differ, the Democratic candidates for president in 2004 are all basically following the approach of the Clinton health plan. They would expand "coverage" with vast subsidies and mandates, encouraging Americans to consume even more medical care. And they would empower others—employers, insurers, and government bureaucrats—to tell consumers when they have had enough.

The candidates' plans reflect a consensus among many observers that rising health care costs must be remedied with additional regulations and subsidies, that the problem of millions of Americans who lack insurance must be addressed by doing whatever expands "coverage." That is understandable. Many people who would like to purchase health insurance find it priced beyond their means, and once one is "covered" many medical expenses are passed on to someone else. This analysis is a misdiagnosis of the problem. Health care costs and the number of uninsured continue to rise, not for lack of government, but because too much government has crippled the normal market processes that make health care of ever-improving quality available to an ever-larger share of the population. The candidates' pro-

posals would add even more government to the mix.

How much more? Between 2005 and 2013, the candidates' proposals would cost anywhere from $591 billion (Edwards) to $6.268 trillion (Kucinich). To put this in perspective, consider that the prescription drug entitlement, recently enacted as part of Medicare reform and considered the largest new government program since the Great Society, is estimated to cost only $410 billion[1] (Figure 1). Financing any of the proposals would require the next president to repeal all of the tax cuts enacted in 2003 ($140 billion from 2005 to 2013) and a significant portion of the tax cuts enacted in 2001 ($1 trillion from 2005 to 2011).[2] The U.S. Department of the Treasury estimates that repealing the 2001 and 2003 tax cuts would raise taxes an average of $1,544 for more than 100 million Americans and cost a married couple with an income of $40,000 and two children $1,933 annually.[3] At least two of the proposals would require further tax increases.

The proposals are likely to cost much more than projected and would add to an already growing burden on taxpayers. Cost projections have repeatedly and famously underestimated future spending on government health programs and other entitlements.[4] Gail Wilensky, who administered Medicare and Medicaid for President George H. W. Bush, said of the new Medicare prescription drug benefit:

> If history is any guide, it will cost more than we think. . . . Not because people are deliberately low-balling the estimates, but because we have never been able to correctly estimate the cost of a new benefit, and this one is much bigger than most.[5]

For example, when Medicare was enacted, hospital costs were projected to be $9 billion in 1990. Actual spending in 1990 was more than $66 billion.[6] There is no reason to believe the costs of the candidates' health insurance proposals will be lower than projected; there is ample reason to believe they will be higher.

Government spending on those proposals would compound the enormous budgetary pressures of existing federal entitlements. The present value of the future fiscal imbalance of Medicare and Social Security alone is

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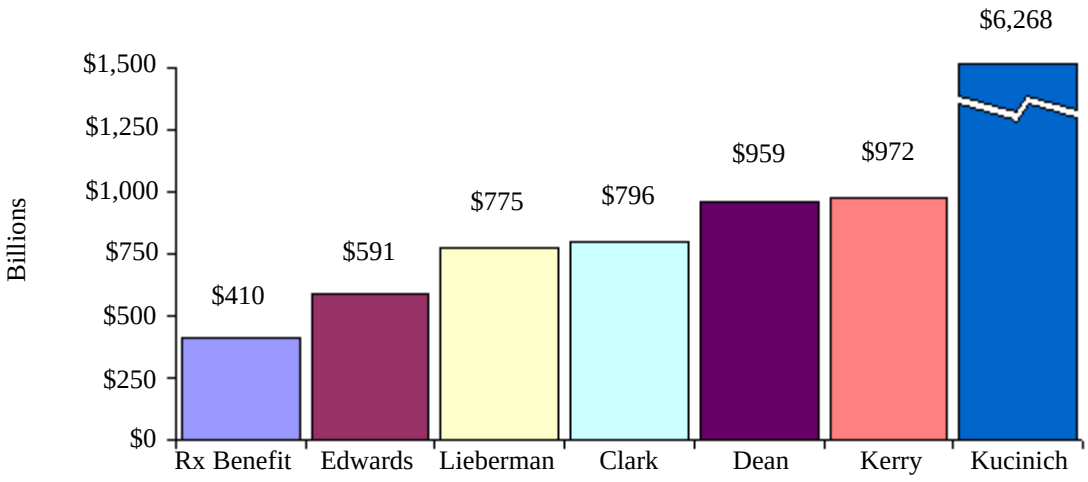
**Figure 1**
**Estimated Costs of Democratic Candidates' Health Insurance Reforms (2005–13) vs. New Medicare Rx Entitlement (2004–13)**




Sources: Kenneth E. Thorpe; Congressional Budget Office; and Kucinich campaign.

estimated to be more than $43 trillion before the new prescription drug benefit is added.[7] Under current law (again before adding the cost of the new Medicare benefit), Social Security, Medicare, and Medicaid will consume nearly 80 percent of federal spending by 2040.[8] In addition to placing new duties on taxpayers, the candidates' health proposals would make existing obligations greater by subjecting Medicare and Medicaid to greater medical inflation.

The cost of those proposals, however, would go well beyond federal outlays. Each would impose hidden costs on employers and workers and lead to greater state government spending. The costs include dampened economic growth resulting from higher tax rates.

People who oppose the influence of money in the political process will find much to dislike about the candidates' health insurance proposals. Each would increase government control over the health care sector and with it the amount of money spent to influence how government exerts that control. By conservative estimates, health care interests spent more than $600 million on political contributions and lobbying activities in the 2001–02 election cycle.[9] Health professionals make the second highest contributions to congressional campaigns.[10] Health care groups ranked second in terms of dollars spent on lobbying activities in 2000.[11] The health care industry's interest in government is a direct result of government's influence over the health care sector. Under any of the candidates' proposals, health care regulation would increase and with it political contributions and lobbying activities of health care interests.

Finally, the candidates' proposals would expand the federal government's power far beyond what the Constitution grants. Fidelity to the Constitution requires reducing federal power over the health care sector.

A positive agenda for improving America's health care system would focus, not on the candidates' paper guarantee of "coverage," but on restoring the market processes that make health care of ever-improving quality available to an ever-greater share of the population.

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## Remembering the Clinton Health Security Act

In 1993 a Clinton administration task force, directed by First Lady Hillary Clinton, devised and proposed a sweeping reorganization of America's health care sector. The Clinton health plan would have increased government controls and exacerbated trends of rising costs and waning consumer sovereignty.

Under the Clinton Health Security Act, the power of individuals to make countless choices about their health care would have been handed over to government, and the few remaining market mechanisms that contain costs and promote quality would have been lost. The federal government would have compelled all Americans to buy health coverage, dictated what type of coverage they would receive and where they would "purchase" it, set prices for coverage and medical services, and encouraged states to form their own single-payer health care systems. Commenting on the Clinton health plan, *The Economist* wrote,

> Not since Franklin Roosevelt's War Production Board has it been suggested that so large a part of the American economy should suddenly be brought under government control.[12]

Though it might have left some private health insurance companies standing, the Clinton health plan would have let government direct the financing of medical care to such an extent that America could no longer have been said to have a private health care system. Rising costs, diminishing quality, and rationing of care would have been exacerbated in the United States as they have been under other socialized health systems. Notable features of the Clinton health plan follow.

**Compelled Behavior**

The most draconian aspect of the Clinton health plan was its mandates on individuals

and employers. The federal government would have compelled Americans to purchase health insurance whether they wanted it or not, forced employers to pay 80 percent of the cost, and subsidized premiums for low-income individuals and small employers. The option to decline health insurance coverage would have become a right no American could exercise, and health insurance "premiums" a tax few could avoid. In 1993 David Rivkin of the American Enterprise Institute commented on the unconstitutionality of the individual mandate:

> In the new health care system, individuals will not be forced to belong because of their occupation, employment, or business activities—as in the case of Social Security. They will be dragooned into the system for no other reason than that they are people who are here. If the courts uphold Congress's authority to impose this system, they must once and for all draw the curtain on the Constitution of 1787 and admit that there is nothing that Congress cannot do under the Commerce Clause. The polite fiction that we live under a government of limited powers must be discarded—Leviathan must be embraced.[13]

**Standard Benefits Package**

The federal government would have controlled the coverage citizens received. A National Health Board would have been vested with the responsibility and power to make billions of decisions that consumers would otherwise have made for themselves. That panel of "experts" would have dictated what types of health insurance Americans would purchase, how much they would pay in premiums, and how much could be spent on health care nationwide.

The board would have been charged with constructing a package of health benefits that all Americans would have had to purchase. Creating a one-size-fits-all standard benefits package ignores the fact that there is no "right" package of benefits. Individuals have different preferences when it comes to health insurance, just as they do when it comes to doctors, cars, and clothes. Imposing the same coverage on everyone means many people will be forced to purchase benefits they do not want. For example, the Clinton health plan would have required Americans to buy coverage for elective abortions.[14] Declining unwanted, government-mandated benefits today can be difficult. It may involve dropping coverage, changing jobs, or even moving to another state. However, any of those is easier than passing a new federal law or leaving the country, which is what would have been necessary under the Clinton health plan. Insofar as a standard benefits package forces consumers to buy benefits they otherwise would not, it encourages them to consume more care to obtain some value for the money they would rather have spent elsewhere.

In addition to the National Health Board, the Clinton plan would have impaneled a National Quality Management Council to develop standards of quality coverage and care. All health plans would have been required to comply with the council's quality guidelines. In effect, the council would have substituted its judgments about quality for those of more than 250 million consumers. It is certain that such a panel's judgments would have delivered quality in some instances and failed in others. Patients adversely affected by the council's judgments, however, would not have had the option of avoiding them. Care could have been delivered only according to the council's guidelines.

**Price Controls**

The National Health Board would have set prices and spending levels for the entire health care sector. No health insurance premium could have exceeded the average for a geographic area by more than 20 percent. Many observers predicted this price control would end fee-for-service health insurance, severely limiting consumer choice. Moreover, the

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health plan's premiums would have been the same for everyone—young and old, healthy and sick—within a politically determined geographic area. Forcing people with below-average needs to subsidize those with above-average needs would have stimulated demand among both groups. The former would have wanted to get the most value for their forced contributions, and the cost of coverage and care for the latter would have been dramatically lowered. The board also would have controlled spending nationwide by drafting global budgets that dictated how much could be spent on medical care in a certain geographic area. Global budgets in other nations have invariably led to rationing of care.[15]

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**Health Alliances**

Another feature of the Clinton health plan was "managed competition": government would bring together private insurers and consumers in an artificial marketplace, much like the Federal Employees' Health Benefits Plan. The Clinton health plan would have created state-based "regional health alliances" to serve everyone within a geographic area, with the exception of those working for certain large employers. The alliances would have been operated by state governments or quasi-governmental agencies and would have been responsible for enforcing the dictates of the National Health Board and the National Quality Management Council. Individuals would have been automatically enrolled in their regional health alliance and in some instances automatically assigned to a plan. Although consumers could have chosen among a few health plans, those options would have been heavily restricted by a standard benefits package, price controls, and other regulations. Moreover, third-party payment and other perverse incentives would have been intensified. The alliances would have created a semblance of competition, but without the economizing incentives that come from allowing risk-based insurance pricing or letting consumers decide how to spend their health care dollars. Consumers would have continued to pay a small fraction of the cost of the medical care they consumed, encouraging them to demand more care but less value. Community rating would have encouraged consumption but discouraged healthy behavior.

Not every American would have been forced into a regional health alliance. Certain large employers would have been allowed to operate their own alliances, though they would have been required to conform to the same benefits, pricing, and quality standards and would have faced other incentives to join a regional alliance. The Clinton health plan also would have encouraged states to launch single-payer health care programs, under which the state would finance medical care for everyone within its borders. Interestingly, federal employees, including members of Congress and many of those who drafted the Clinton health plan, would have been excluded from regional alliances for four years after the first Americans were forced to enroll. Had the regional alliances not met the planners' expectations, that would have granted politically powerful federal workers enough time to carve themselves out of the alliances permanently.

**Higher Taxes**

The Clinton health plan would have resulted in a massive tax increase. The Clinton administration initially estimated its health plan would save taxpayers money, though few people believed that prediction. As one observer noted at the time:

> [V]irtually all of the perverse incentives of the current system are to be left in place, while the Administration is expanding coverage for the millions who are uninsured. This amounts to a stimulation of demand, combined with a constriction of supply. This is akin to turning up the heat on a pressure cooker, while clamping down on the lid. At some point, the lid will blow and the costs of the system will skyrocket in bigger deficits and even higher taxes.[16]

Under heavy criticism, the Clinton administration was forced to admit the program would cost taxpayers an additional $700 billion over five years, and some observers maintained it would cost significantly more in higher tax revenue and lower economic growth.[17]

**An Incremental Approach**

The Clinton health plan was so massive in scope that it collapsed of its own weight. Since its defeat, supporters of greater government control over the health care sector have focused on incremental rather than wholesale measures. As President Clinton told a group of supporters in 1997:

> I'm glad I tried to do the health care plan. . . . Now that what I tried to do before won't work, maybe we can do it in another way. That's what we've tried to do, a step at a time, until eventually we finish this.[18]

One of those steps already has been taken. Internal documents from the Clinton administration's health care task force reveal the group considered a number of options for phasing in "universal coverage" starting with children. Phasing in full government control first for children and then later for adults was discussed with the task force by a senior aide to Sen. Edward Kennedy (D-MA), a longtime advocate of a single-payer system.[19] In 1997, with the help of Senator Kennedy, the Clinton administration created the State Children's Health Insurance Program, which expanded government financing of health care to cover more low-income children. The 2004 Democratic presidential candidates' proposals would take the next several steps down this road.

## 2004: The Democratic Presidential Candidates

Many features of the Clinton health plan have resurfaced in the health platforms of the Democratic candidates for president in 2004: expanding government health programs; individual and employer mandates; a standard benefits package; government quality standards; price controls; health insurance subsidies; exemption of federal workers from rules that govern others; and higher taxes, both explicit and hidden. One ostensible difference is the proposal to use tax credits to expand insurance coverage (Clark, Dean, Edwards, Kerry, Lieberman). Although tax credits have the potential to curb third-party payment and improve consumer choice through a more equitable distribution of the tax subsidy for health insurance, the tax credits proposed by the candidates would do little more than subsidize greater consumption of health care. The five leading candidates (Clark, Dean, Edwards, Kerry, Lieberman) would expand government control over the health care sector incrementally and subsidize health insurance with refundable tax credits. The two long shots (Kucinich and Sharpton) would go well beyond even the Clinton health plan and establish a nationwide single-payer system.

**Features Common to All Plans**

***Higher Taxes, Hidden Taxes.*** The costs of all of the plans for which cost estimates are available would far outstrip the cost of the recently enacted Medicare prescription drug benefit. The least expensive plan (Edwards) would cost a projected 40 percent more in 2013. The most expensive proposal (Kucinich) would cost nearly 17 times as much.[20] The cost estimates are likely to understate actual government outlays and do not account for additional hidden costs.

Financing any of the candidates' proposals would require the next president to repeal all of the tax cuts enacted in 2003 ($140 billion from 2005 to 2013) and a significant portion of the tax cuts enacted in 2001 ($1 trillion from 2005 to 2011).[21] All of the candidates have endorsed repealing a significant portion of those tax cuts. Some propose additional tax increases. Kucinich would impose a 7.7 percent payroll tax to finance a single-payer system.

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***Expanding Government Programs.*** Each candidate would expand the reach of government health programs. Even the incremental expansions of Medicaid and SCHIP proposed by some candidates (e.g., Dean) rival the cost of the new Medicare prescription drug benefit. The expansions would increase the "entitlement" attitude toward health care and diminish private-sector coverage. Again, the proposals of the five leading candidates would crowd out private health insurance by as much as 50 percent of the proposed expansions.[22] The proposals of Kucinich and Sharpton would crowd out the entire private health insurance industry.

***Price Controls.*** Each candidate would expand the reach of government price controls by expanding government programs at the expense of private-sector coverage. Government-determined prices would be imposed on more transactions, and the share of prices set by private payers would shrink. In proposals containing health alliances (see below), premiums would be community rated, creating a disincentive for younger and healthier risks, attracting more expensive risks, and putting taxpayers on the hook for the costs of adverse selection.

***Standard Benefits Packages.*** Each proposal would give government greater power to dictate the type and level of health benefits consumers would receive. This most obviously would occur in government programs, but candidates who would preserve a private health insurance market would mandate that consumers purchase government-ordained benefits. Some would require certain types of coverage and measures of quality, while others would prescribe appropriate deductibles and copayments.

**Features Common to Some Plans**

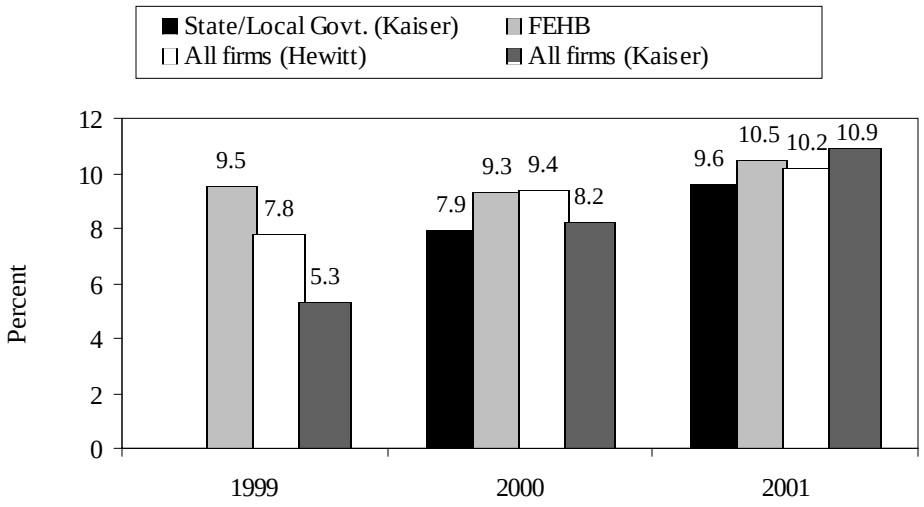
***Individual and Employer Mandates (Clark, Dean, Edwards, Kucinich, Lieberman).*** Forcing consumers to do what government wants is particularly detrimental to the goal of determining what consumers want. Several candidates would either compel certain individuals to obtain coverage or compel employers to provide coverage for some or all workers. The mandates would be enforced by various tax penalties.

***Automatic Enrollment and Government Monitoring of Insurance Status (Clark, Dean, Edwards, Kerry, Lieberman).*** Several candidates would set up procedures to enroll individuals automatically in government health programs or monitor their insurance status, or both. Status would be monitored through schools, the Internal Revenue Service, or other government agencies. Candidates proposing single-payer systems (Kucinich and Sharpton) have not specifically addressed these issues.

***Tax Credits (Clark, Dean, Edwards, Kerry, Lieberman).*** Several candidates propose subsidizing health insurance through refundable tax credits aimed primarily at low-income Americans (a concept also endorsed by President Bush). That all five of the leading candidates propose tax reform to improve health care indicates significant recognition of the tax code's role in shaping that sector. However, the proposed tax credits fail to offer consumers true choice or curb third-party payment. In effect, many would be not tax credits but welfare payments. Many are targeted to employers rather than individuals and may only be used toward coverage that includes what in some cases would be a highly prescriptive standard benefits package. Credits could be used only for coverage through an employer, a health alliance, or a government program. No candidate has announced—and some have denied—that his proposed tax credit could be used in the individual market or in conjunction with health savings accounts (see below). Without the choice of purchasing insurance wherever the recipient chooses, or the ability to use the credit toward health savings accounts, the candidates' tax credits would increase rather than limit third-party payments, lead to even greater health spending, and invite additional government controls.

***Health Alliances (Clark, Dean, Edwards, Kerry, Lieberman).*** Nearly all the candidates support creating government-sponsored

**Figure 2**
**FEHBP Premium Increases vs. Those of Other Employers, 1999–2001**




Sources: Congressional Research Service; Kaiser Family Foundation; and Hewitt & Associates.

health alliances, or purchasing pools, from which individuals or employers could purchase coverage with government subsidies (tax credits) at government-controlled prices.

Though health alliances can give consumers a choice of plans, the candidates' proposals would do little to improve consumer choice or restore market signals. For example, health alliances in themselves do nothing to reduce third-party payment. Moreover, they would determine the design of the plans, set the premiums and allowable profits, and force taxpayers to cover insurers' losses.

Judged against the goals of expanding health coverage and controlling costs, health alliances have come up short. Economists with RAND Health studied statewide health alliances in California, Connecticut, and Florida and found "the alliances did not have their intended effects. They did not increase the percentage of small businesses that offered health insurance, nor did they reduce small-group market health insurance premiums."[23] Candidates who would fund health alliances claim they would be modeled on the Federal Employees' Health Benefit Plan. Yet FEHBP has had no more success controlling the rising cost of insurance than have private plans (Figure 2). FEHBP plans are community rated, which has led to adverse selection and is likely one reason 20 percent of eligible federal workers decline coverage,[24] compared to 14 percent of eligible workers in large firms.[25] As a sign of what would await federally chartered health alliances, Congress has shown increasing willingness to enact mandates that increase the cost of FEHBP coverage.[26]

A flexible, centrally planned government program such as FEHBP makes better use of market processes than a rigid centrally planned program like Medicare, which makes FEHBP a possible model for Medicare reform. However, a flexible centrally planned program still makes less use of consumers' knowledge and market incentives than a private market, deregulated and divested of government preferences for third-party payment.

Some candidates claim their health alliance proposals would enhance market competition. However, with government designing the product, setting its price, paying for it, determining acceptable profit levels for the people who provide it, and in some cases forcing individuals to consume it, it is

**With government designing the product, setting its price, and paying for it, it is difficult to argue that health alliances would be anything but a government program.**

**Gen. Wesley Clark proposes to increase taxes, compel children and young adults to obtain coverage, provide tax credits for low-income Americans, and impose a standard benefits package on all public and private health plans.**

difficult to argue that health alliances would be anything but a government program.

**Reforms Missing from All Plans**

***Health Savings Accounts.*** Each of the candidates' proposals would exacerbate the problem of third-party payment. Fortunately, Congress has already enacted real reform that will curb third-party payment by restoring incentives for patients to be prudent consumers.

Starting in January 2004, health savings accounts (HSAs) became available to most nonelderly Americans. HSAs combine a tax-free savings account dedicated to medical expenses with a high-deductible health insurance policy. Individuals who purchase health insurance with a deductible between $1,000 and $2,600—and families with health insurance deductibles between $2,000 and $5,150—can contribute the amount of the deductible to an HSA. Funds in the HSA cover expenses up to the deductible tax-free, at which point insurance takes over.

HSAs eliminate the tax subsidy's preference for third-party payment (if not the subsidy itself) by allowing consumers to keep whatever HSA funds they do not spend, which grow tax-free. HSAs thus make consumers more prudent shoppers for medical care. They further give consumers the security to leave an employer plan and purchase coverage that meets their own needs. HSAs let consumers' spending patterns voice consumers' preferences to producers and make available more information about what consumers value than any other health insurance reform to date.

***Regulatory Choice.*** State lawmakers are able to enact excessive health insurance regulations because they are insulated from competition by laws that restrict interstate commerce by prohibiting their residents from purchasing health insurance regulated by more consumer-friendly states. Allowing consumers to purchase health insurance regulated by the state of their choice would let them decide which regulations are justified and which are excessive and would discourage overregulation.[27]

## A Look at the Candidates' Plans

A description and analysis of each candidate's health insurance reform proposals follow.

**Gen. Wesley Clark**

Army Gen. Wesley Clark (ret.) proposes to increase taxes, compel children and young adults to obtain coverage, expand existing government health programs, create a new national health insurance purchasing alliance, provide tax credits for low-income Americans to purchase government-approved coverage, and impose a standard benefits package on all public and private health plans.[28] The Clark plan would cost federal taxpayers an estimated $796 billion over 10 years. By 2013 the Clark plan is projected to cost $174 billion annually and to extend coverage to an estimated 31.8 million currently uninsured individuals.[29]

***Expanding Government Health Programs.*** The Clark plan would expand Medicaid and SCHIP to cover all children and young adults under age 23 in a family below 150 percent of the federal poverty level, or FPL, (see below for costs and number of newly insured).

Medicaid would be expanded further to cover all adults, including single adults and childless couples, up to 150 percent of the FPL, at a cost of $282.1 billion from 2005 to 2013, and cover an estimated 11.3 million currently uninsured adults. The cost of those expansions would be borne by the taxpayers.

***Health Alliances.*** The Clark plan would create a nationwide health alliance called the Congressional Health Plan modeled on the FEHBP. The Clark plan would also distribute funds to states to create state-based alliances from which small employers could purchase group coverage. The cost of providing coverage to an estimated 1.1 million currently uninsured individuals without access to employer-provided coverage through the Congressional Health Plan is estimated to be $34.6 billion over the 2005–13 period ($5.6 billion in 2013).

***Tax Credits.*** The Clark plan would introduce three types of tax credits to be used toward health insurance. Each would phase out as an individual's or family's income rose. Parents with incomes up to five times the FPL would receive a tax credit toward the purchase of health insurance for their children through an employer plan, Medicaid, SCHIP, or the new Congressional Health Plan. Adults under age 23 would receive the same tax credit to purchase insurance for themselves. The tax credits and Medicaid and SCHIP expansions for children and young adults would cost an estimated $291.9 billion for 2005 through 2013 ($53.9 billion in 2013) and cover an estimated 13.1 million currently uninsured individuals.

A tax credit would be available to all adults between 150 percent and 275 percent of the FPL to be used toward the purchase of employer-provided insurance or coverage through the Congressional Health Plan, at a cost of $169.6 billion from 2005 through 2013, and would cover an estimated 4.9 million currently uninsured individuals.

Workers earning up to five times the FPL who left their jobs would receive a temporary tax credit equal to 70 percent of the cost of coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) or coverage under the Congressional Health Plan ($17.6 billion over 2005–13; $2.9 billion in 2013) and provide coverage to an estimated 1.4 million currently uninsured individuals.

***Government Controls.*** The Clark plan would require children and adults up to age 22 to have health insurance. Children's health insurance status would be monitored by schools and other arms of the government, including the Internal Revenue Service. Parents would furnish proof of children's coverage on their income tax forms. Children found not to be covered would be automatically enrolled in Medicaid or SCHIP. Young adults who did not obtain coverage or parents who did not cover their children would pay tax penalties, such as the loss of a child exemption.

The Clark plan would create a new, permanent government commission of "scientists, health care professionals, health service researchers, consumers and health economists"[30] that would issue recommendations on the value of preventive care and the relative value of different medical interventions. Further, the commission would recommend model health coverage designs that would determine "appropriate" levels of cost sharing and eliminate "excessive" deductibles and copayments. "[A]ll federal health programs, including safety net providers, would guarantee that their benefits are comparable to the Commission's recommendations."[31] Over time, "adoption of recommended services could eventually become a prerequisite for any type of tax subsidy."[32] The Clark plan would initially provide subsidies to promote, but eventually would require medical providers and health insurers to adopt, "information and communications technology such as electronic medical records, computer-aided decision tools, reminder systems and medication order entry systems."[33]

Insurers that participated in FEHBP would be required to offer the same health insurance products as the Congressional Health Plan. Participating insurers would be required to issue coverage to all applicants (guaranteed issue). Premiums in the Congressional Health Plan would be set by the federal government at the average cost of insuring all adults age 23 to 64 (community rating). Taxpayer subsidies would cover the losses of participating insurers.

The Clark plan emulates the Clinton health plan, albeit incrementally. It would compel coverage of children and young adults. Their coverage status would be monitored, and failure to comply would result in greater tax liability. However, people who do not cover themselves or their children already pay an additional tax today because they forgo the tax benefits of employer-provided health insurance.

The Clark plan also would expand the reach of government health programs, thereby shrinking the private health insurance market. Increasing the eligibility thresholds for Medicaid and SCHIP would shift to tax-

**The Clark plan emulates the Clinton health plan, albeit incrementally.**

payers burdens that are already being borne voluntarily by consumers and employers. Furthermore, it would expand the reach of Medicaid payment rates, which would diminish the quality of coverage for those who drop private coverage to enroll.

The Clark plan's value commission would wield powers similar to those of the National Health Board under the Clinton health plan. The commission would have the power to dictate what coverage benefits consumers nationwide would have to purchase. Its "recommendations" on benefits, including deductibles and copayments, would be imposed on all federal health programs, including the new nationwide health alliance. Making compliance with the commission's recommendations "a prerequisite for any type of tax subsidy" would effectively give the commission the power to set benefits for the private sector as well.

The Clark plan's proposed nationwide health alliance is problematic for taxpayers. Premiums would be set according to a nationwide average of the anticipated health needs of adults aged 23 to 64. For simplicity, assume 50-year-olds represent average health expenditures in this group. With prices for all health plans set at the cost of insuring a 50-year-old, those above age 50 would flock to the program while the better risks would avoid it. Enrollees above age 50 would receive an implicit subsidy encouraging them to consume more care. Enrollees below age 50 would be few, but they would face incentives to overconsume care in order to get some value for the extra premiums they would pay. Moreover, since the Congressional Health Plan would guarantee coverage at a fixed rate regardless of health status, eligible individuals would wait until they were sick before signing up for insurance. All told, the cost of covering likely participants in the Clark CHP will be well above the amount collected in premiums, and taxpayers will pick up the difference.

The tax credits offered under the Clark plan would provide a tax break, and in some cases a welfare payment, for purchasing health insurance. For parents and young adults, the tax credits would supplement forced spending on health insurance. The availability of tax credits for low-income workers and the CHP for those without access to employer coverage would encourage employers of low-wage workers to drop coverage, shifting even more private spending to taxpayers. Those factors would also further weaken the individual health insurance market, where consumers would receive no tax subsidy, by encouraging flight to the Congressional Health Plan. The tax credit for people eligible for COBRA would offer significantly less choice than the tax credit currently available for displaced workers. The requirement that those programs and private health plans offer a standard benefits package would further limit consumer choice in the private market. Moreover, the Clark tax credits would do nothing to curtail third-party payment or encourage consumers to demand greater value.

The Clark plan would expand the reach of government health programs at the expense of private health insurance. The result would be an expansion of third-party payment and consumer demand, putting greater inflationary pressure on medical prices and thereby imposing enormous burdens on taxpayers, not just for the proposed spending but also for the increased cost of the obligations already incurred under Medicare and Medicaid. By increasing budgetary pressures and government control over health spending in both the public and the private sector, the Clark plan invites greater government rationing of medical care.

**Howard Dean would enact explicit and hidden taxes, expand government health programs, compel many large employers to offer coverage to all workers, and impose a standard benefits package on all Americans.**

**Gov. Howard Dean**

Former Vermont governor Howard Dean, himself a physician, would enact explicit and hidden taxes, expand government health programs, compel many large employers to offer coverage to all workers, have government monitor individuals' coverage status and automatically enroll eligible people in government health programs, create a national health alliance, and impose a standard benefits pack-

age on all Americans.[34] From 2005 to 2013 the Dean plan would cost $959 billion ($148 billion in 2013) and cover an estimated 30.2 million previously uninsured individuals.[35]

***Expanding Government Health Programs.*** The Dean plan would expand SCHIP and rename it the Family & Children Health Insurance Program. The program would be open to children and adults under age 25 with family incomes up to 300 percent of the FPL and cost an estimated $306.2 billion over 2005–13 ($47.1 billion in 2013). It would also be open to adults between ages 25 and 64 with incomes up to 185 percent of the FPL ($379.1 billion over 2005–13; $58.9 billion in 2013). The current six-month waiting period for SCHIP participation would be waived for people experiencing a change in employment. The federal government would fund the expansion, which would cover an estimated 11.4 million currently uninsured children and 12.5 million currently uninsured adults.

***Health Alliances.*** The Dean plan would create a national health alliance called the Universal Health Benefits Program. The UHBP would offer "coverage identical to what members of Congress and federal employees get" through FEHBP[36] to all individuals not eligible for FCHIP, Medicaid, or Medicare ($126.6 billion over 2005–13; $20.3 billion in 2013; 3.9 million newly insured),[37] as well as small employers and the self-employed ($100.3 billion over 2005–13; $14.9 billion in 2013; 800,000 newly insured).

***Tax Credits.*** The Dean plan would provide tax credits to Americans who are uninsured for six months and who are not already eligible for FCHIP, Medicaid, or Medicare. The amount of the credit would be the difference between 7.5 percent of the taxpayer's adjusted gross income and the premium of the UHBP standard health plan of his choice. The Dean plan would pay 70 percent of the premium for workers who use COBRA coverage for more than two months ($46.8 billion over 2005–13; $6.6 billion in 2013; 1.9 million newly insured).

***Government Controls.*** Under the Dean plan the federal government would monitor individuals' insurance status through the Internal Revenue Service. Individuals would demonstrate proof of insurance when filing taxes. Those without health insurance would have to either affirmatively opt out of government coverage or be enrolled automatically in a government health program for which they were eligible. Individuals so enrolled would have to opt out within a certain time period or pay premiums to the program.

The Dean plan would impose a number of hidden taxes on employers. First, it would reduce or eliminate tax deductions or federal contracts, or both, for large firms that did not offer coverage to all employees. Second, it would require all employer health plans to cover dependents through age 24. Third, it would require employers to continue paying their portion of an employee's health premiums for two months after separation from an employee if the employee opted for COBRA coverage.

The Dean plan would create a new Health Care Institute to direct cost/benefit research on new medical technologies, examine new ways of financing health care, serve as an information clearinghouse, and focus on "implementation, not just research."[38] Next, the Dean plan would require all insurers and providers to use federally standardized electronic systems for patients' medical records, billing, and prescriptions. The Dean plan would also convene a White House Conference on Healthcare Effectiveness to make further recommendations regarding health benefits and the practice of medicine, again focusing on implementation of its recommendations. Health plans in the UHBP would be required to offer a standard benefits package, much like FEHBP plans. Insurers participating in the UHBP would be required to issue coverage to all applicants (guaranteed issue), and premiums would be set by government at the average cost of insuring all adults aged 23 to 64 (community rating). Taxpayer subsidies would cover insurers' losses when claims exceeded premiums.

The Dean plan would expand government health programs to the exclusion of private

**Under the Dean plan the federal government would monitor individuals' insurance status through the Internal Revenue Service.**

health insurance and shift costs from employers and workers to taxpayers. Crowd-out in the UHBP health alliance would be lessened by the six-month waiting period. However, crowd-out due to the expansion of eligibility under FCHIP would be aggravated by elimination of the six-month waiting period for enrollment by people changing jobs.

Cost projections for the Dean plan do not include the hidden taxes it would impose on employers. For example, the mandate that employers continue to pay their portion of an employee's health premiums for the first two months of COBRA eligibility would impose costs on employers. Workers who opt for COBRA coverage tend to have high medical expenses. In addition, firms' premiums would rise because of higher claims costs resulting from greater use of COBRA coverage. Eliminating tax deductions or federal contracts for large employers who do not offer health benefits to all workers is a tax that is tantamount to an employer mandate. The requirement would apply to all large firms, whether they currently offer health benefits or not, though it would fall most heavily on firms that do not offer coverage. Of uninsured adults who work in large firms, 71 percent lack coverage because their employer does not offer it.[39] By shifting compensation to health benefits, this mandate would reduce workers' wages. It would also eliminate jobs. More than half (57 percent) of large-firm employees who are uninsured because they are ineligible for health benefits are part-time workers.[40] Large firms likely would eliminate many of those positions and replace the workers with contract workers from smaller firms not subject to the mandate. Such a mandate would lend itself to expansion. If shifting to contract workers thwarted the mandate's goal of expanding coverage, lawmakers would likely expand the mandate to include smaller firms.

The Dean health alliance would create the same problems as the Clark health alliance (see above). Though Dean's new federal health bureaucracies would have less power initially than the Clinton National Health Board, the focus on "implementation" of their "recommendations" lends itself to imposition of mandates. As governor, Dean once told Vermont's legislature: "State-passed mandates have contributed about 25 percent of this year's increase in insurance premiums. Many of these I have supported. But this year, I ask the legislature not to pass any additional mandates."[41] As a presidential candidate, Dean has already proposed federally mandated medical records, billing, and prescriptions systems. Further, he has endorsed a federal law that would require parity between mental health benefits and medical and surgical benefits in private employer plans that offer both.[42] The Congressional Budget Office estimates this mandate could increase mental health costs in affected plans by 30 to 70 percent, increase Medicaid and SCHIP spending by more than $600 million over 10 years, and increase premiums for affected plans by one percentage point or more,[43] an increase the Lewin Group estimates is enough to cause 300,000 Americans to lose private coverage.[44]

The Dean plan would expand the power of the federal government and increase health insurance subsidies, and it would fail to expand consumer choice or curb third-party payment.

**Sen. John Edwards's health care reform plan would increase taxes, subsidize health consumption through restrictive tax credits, and dictate what health benefits consumers must purchase.**

**Sen. John Edwards**

Sen. John Edwards's health care reform plan would increase taxes; compel coverage of children and young adults through age 21; monitor their health insurance status; expand Medicare and SCHIP; increase spending on Medicaid; create state-based health alliances; subsidize health consumption through restrictive tax credits; and dictate what health benefits consumers must purchase, including types of coverage and levels of cost sharing.[45] The Edwards plan would cost a projected $590.1 billion from 2005 to 2013 and cover an estimated 21.7 million currently uninsured individuals. By 2013 it would cost an estimated $104 billion per year, or nearly twice the cost of the new Medicare prescription drug benefit.[46]

***Expanding Government Health Programs.*** The Edwards plan would allow individuals aged 55 to 64, and younger spouses of Medicare beneficiaries, to "buy in" to Medicare at a cost of $10 billion from 2005 to 2013 ($1.5 billion in 2013), thus covering an estimated 600,000 previously uninsured individuals. SCHIP would be expanded to include all adults, including single adults and childless couples, with incomes up to 250 percent of the FPL. Adults with incomes up to 100 percent of the FPL could enroll in SCHIP at no cost. Those with incomes between 100 percent and 250 percent of the FPL would contribute to the cost of SCHIP coverage, though states could reduce contributions for those under age 25. The federal government would make benefits appropriate for adults, eliminate waiting periods, and pay all costs of the SCHIP expansion.

***Health Alliances.*** The Edwards plan would subsidize state-based health purchasing alliances through a new Small Business Support Program. The SBSP would help states set up alliances for small employers and the self-employed to purchase coverage that private insurers would make available to all participating firms.

***Tax Credits.*** The Edwards plan would allow three types of refundable tax credits. Families with incomes up to five times the FPL who were not already eligible for Medicaid or SCHIP would receive a credit for coverage either in an employer-provided health plan or SCHIP. Tax credits could not be used in the individual market. Families that used the tax credit for employment-based coverage could receive supplementary services from Medicaid or SCHIP. The Edwards child coverage subsidies would cost an estimated $240 billion from 2005 to 2013 ($42.5 billion in 2013) and cover an estimated 8.7 million currently uninsured children. Subsidies for adults would total $325 billion over the nine-year period ($58.3 billion in 2013) and cover an estimated 11.4 million currently uninsured adults.

COBRA-eligible workers with family incomes up to 250 percent of the FPL would receive a credit equal to 70 percent of their COBRA premiums, at an overall cost of $14.9 billion over the 2005–13 period ($2.1 billion in 2013); an estimated 1 million previously uninsured individuals would be covered.

Small businesses with a majority of low-income employees would receive a tax credit for participating in the new SBSP health alliances. (Projected costs and number of newly insured are included in the child and adult estimates.)

***Government Controls.*** The Edwards plan would require parents to obtain coverage for their children and would require young adults to obtain coverage up to age 21. Children's insurance status would be monitored by government. Children would be enrolled in government programs automatically "when they are born, when they register for school, when they come to health clinics, or when a parent files a tax return."[47] Parents who failed to purchase coverage for their children or enroll them in a government program would first receive a warning from the government. Parents who still failed to cover their children would lose unspecified tax benefits and their children would be "automatically enrolled in the appropriate program."[48] The Edwards plan would require employers and insurers to offer "affordable" coverage for dependents up to age 25.[49]

The Edwards plan would make tax credits applicable only to health plans that adopted federal government standards for "high-quality" coverage and "reasonable" cost sharing (copayments and deductibles). Health plans would be required to provide coverage at least as generous as SCHIP, and specific benefits would be mandated, including age-appropriate vaccinations with no copayments and mental health parity.[50] Health plans also would be governed by a "patients' bill of rights" that would codify a federal definition of what is "medically necessary," prohibit certain cost-control techniques, and expose insurers and employers to increased liability. The Edwards plan would require insurers, providers, and patients to use federally standardized electronic medical records

**The Edwards plan would make tax credits applicable only to health plans that adopted federal government standards for "high-quality" coverage and "reasonable" cost sharing (copayments and deductibles).**

**Sen. John Kerry proposes to expand government health programs, create a national health alliance, enact new health insurance subsidies, and offer states a "swap" that could leave them with larger than expected health obligations.**

for provision of care and billing; that information would be stored in a national database.

Like the Clark plan, the Edwards plan would compel children and young adults to obtain coverage and use the Internal Revenue Service and other government agencies to monitor compliance. Also like Clark, Edwards would develop government standards for coverage benefits, including deductibles and copayments, and use the tax code to impose those standards on private health insurance. (Whereas Edwards would make adoption of the federal standard benefits package mandatory for use of a tax credit, Clark would condition any tax subsidy on adoption of the standard benefits package.)

The Edwards plan's restrictive tax credits could be used only toward employer or government health plans. Without the option of purchasing individual coverage or the ability to curb third-party payment with HSAs, the tax credits would merely be a subsidy that would lead to higher health care costs.

**Sen. John Kerry**

Sen. John Kerry proposes to expand government health programs, create a national health alliance, enact new health insurance subsidies and restrictive tax credits, define a standard benefits package for all Americans, and offer states a "swap" that could leave them with larger than expected health obligations.[51] The Kerry plan would cost a projected $972 billion from 2005 to 2013 and cover an estimated 26.7 million currently uninsured individuals. Its expected cost in 2013—$157 billion—is more than twice that of the new Medicare prescription drug benefit.[52]

***Expanding Government Health Programs.*** The Kerry plan would offer states a "swap." States would be asked to extend SCHIP eligibility to all children in families with incomes up to 300 percent of the FPL, then to all families with incomes up to 200 percent of the FPL, and, "[o]nce states get back on course to a more secure financial footing,"[53] to all adults (including singles and childless couples) below 100 percent of the FPL. States also would be asked to eliminate the five-year waiting period for legal immigrant children and pregnant women, allow disabled children to remain enrolled when their parents begin work, and enroll 95 percent of all eligible children in Medicaid and SCHIP. In return, the federal government would assume the cost of all children enrolled in a state's Medicaid program and provide states an enhanced federal matching rate for SCHIP. The Medicaid and SCHIP expansions would cost the federal government an estimated $502.7 billion from 2005 to 2013—123 percent of the cost of the Medicare prescription drug benefit—including $17.4 billion in 2013. They would cover an estimated 18.1 million currently uninsured Americans.

The Kerry plan also would create a new federal reinsurance program. A "premium rebate" program would reimburse employer and health alliance plans for 75 percent of the cost of employee medical claims in excess of $50,000. The program would cost an estimated $288.5 billion from 2005 to 2013 including $50.4 billion in 2013, accounting for nearly one-third of the cost of the Kerry plan. The premium rebates would cover an estimated 2.1 million workers.

***Health Alliance.*** The Kerry plan would create a nationwide health alliance called the Congressional Health Plan. Participation would be open to all individuals and employers. Insurers participating in the FEHBP would be required to offer the same health plans as the Kerry health alliance would offer, though each would operate as a different pool. The program would cost an estimated $79.1 billion from 2005 to 2013 ($11.5 billion in 2013) and cover an estimated 2.5 million currently uninsured workers.

***Tax Credits.*** The Kerry plan would provide tax credits to small businesses participating in the health alliance for up to half the cost of coverage, to individuals aged 55 to 64 ($9.2 billion from 2005 to 2013; $1.3 billion in 2013; 600,000 newly insured), and to low-income individuals for premium costs above 6 percent of adjusted gross income ($39.4 billion from 2005 to 2013; $6.5 billion in 2013;

1.8 million newly insured). The Kerry plan also would provide workers eligible for unemployment benefits a tax credit for 75 percent of the cost of COBRA coverage ($53.2 billion from 2005 to 2013; $7.7 billion in 2013; 1.8 million newly insured).

***Government Controls.*** The Kerry plan would automatically enroll children in Medicaid or SCHIP at their schools or community health centers. To participate in the Kerry health alliance, large employers would be required to maintain the same contribution they currently make to employee health premiums and not segment their employees into the health alliance. Employers who currently offer coverage would be required to pay an entry fee equal to 10 percent of the firm's total premiums (to reduce adverse selection). Health plans would be required to offer family coverage to domestic partners. They would also have to use new federally mandated electronic records systems. Health plans within and outside the health alliance would be required to offer specific benefits, including disease management and mental health parity. To qualify for the new federal reinsurance program, the Kerry plan would require employers to provide "affordable coverage to all their employees"[54] and to demonstrate that the savings from reinsurance were used to reduce workers' premiums.

States could end up the losers under the Kerry plan's "swap." A common feature of government health programs is that the most generous benefits go to the most politically powerful beneficiaries. For example, Medicare provides higher quality service and greater choice of doctors than Medicaid because Medicare's constituency—senior citizens—is better organized and more politically active. Even within Medicare, benefits are allocated on the basis of politics. Medicare pays for many routine items because routine care is used by many voters. However, Medicare leaves beneficiaries responsible for many catastrophic expenses because such coverage benefits fewer voters.[55] Under the "swap," the federal government would assume greater responsibility for Medicaid, which serves the poorest Americans. In exchange, states would assume greater obligations to relatively more affluent individuals through SCHIP. Over time, the more affluent SCHIP families likely would demand, and get, a higher level of care than Medicaid families. That would leave states with greater obligations relative to those assumed by the federal government under the Kerry plan's "swap."

The Kerry reinsurance program would subsidize greater consumption and could lead to significant litigation. It would provide enormous incentives for health plans to provide more generous care—health plans would pay only $250 for every additional $1,000 of care above $50,000 in claims. The Kerry campaign notes that 0.4 percent of private insurance claims are above $50,000, yet those claims account for nearly 20 percent of all claims costs. The Kerry plan's subsidy of high-end claims would increase both the share and the amount of claims above the $50,000 threshold. At the same time, employers and insurers would be required to demonstrate that the savings were passed on to workers, with the expectation of savings as high as $1,000 for a family plan. Insurers and employers would be caught between patients in medical need who would want the subsidy passed on to them (knowing that the health plan would pay only 25 cents on the dollar for the treatment they want) and government bureaucrats demanding the subsidy be passed on to all workers through lower premiums. Even if the savings were passed on to workers, that still could result in greater spending as employers faced existing and enhanced incentives (i.e., small business tax credits for participating in the Kerry health alliance) to convert the savings into more generous health benefits.

Though it would have two different pools, the Kerry plan could reduce choice for federal employees by requiring insurers to offer the same plans in both programs. Like the Dean plan, the Kerry plan's requirement that employers participating in the new health alliance provide "affordable coverage to all their employees"[56] would encourage firms to

**States could end up the losers under the Kerry plan's "swap."**

replace low-wage workers with contract workers.

**Sen. Joseph Lieberman**

The Lieberman plan would increase taxes, expand government health programs, create national and state-based health alliances, grant restrictive tax credits, dictate a standard benefits package, and impose mandates on employers.[57] The proposal would cost an estimated $775 billion from 2005 to 2013 ($150 billion in 2013)—more than twice the projected cost of the Medicare prescription drug benefit.[58] It would cover an estimated 31.6 million previously uninsured individuals.

***Expand Government Health Programs.*** The Lieberman plan would expand Medicaid to cover all individuals with incomes up to 150 percent of the FPL (including single adults and childless couples) and expand SCHIP to include all children and young adults up to age 25 in families with incomes up to 300 percent of the FPL, low-income pregnant women, and legal immigrant pregnant women and children. The federal government would assume 100 percent of the cost of newly eligible children and would increase funding to states that enrolled 90 percent of all eligible children. The Medicaid expansion would cost an estimated $270 billion from 2005 to 2013 ($47.7 billion in 2013) and would cover an estimated 9.3 million currently uninsured individuals. Expanding SCHIP would cost an estimated $151 billion from 2005 to 2013 ($25.9 billion in 2013) and cover an estimated 7.2 million currently uninsured individuals.

***Health Alliances.*** The Lieberman plan would create nationwide and state-based health alliances modeled on the FEHBP. The first, MediKids, would be open to all children and young adults up to age 25. Children eligible for Medicaid and SCHIP would be permitted to enroll, with the aid of tax credits (see below).

The second, MediChoice, would be open to all individuals without access to "affordable, conventional group health insurance," including those without access to employer coverage for six months; self-employed, unemployed, part-time, seasonal, contract, temporary, and temporarily disabled workers; workers receiving unemployment insurance and workers eligible for COBRA (for one year); early retirees between the ages of 55 and 64 without access to employer coverage; stay-at-home moms; small firms (with fewer than 50 employees and that contribute two-thirds of the cost of worker premiums); and employees of large firms whose health premium contribution exceeds 7.5 percent of adjusted gross income. States would have the option of administering their own MediChoice programs or participating in a federal MediChoice pool.

***Tax Credits.*** The Lieberman plan would grant tax credits to those participating in MediKids and MediChoice. Families at or below 150 percent of the FPL would receive tax credits equal to 100 percent of their children's MediKids premiums. MediKids tax credits for families between 150 and 300 percent of the FPL would be set according to an income-based sliding scale, with no families paying more than 7.5 percent of their income in premiums. MediKids-related tax credits are projected to cost $97.6 billion from 2005 to 2013 ($30.0 billion in 2013) and cover 7.5 million currently uninsured children.

People eligible for MediChoice would receive tax credits toward MediChoice plans or private market coverage with the federal standard benefits package. The amount of the credit would be based on the average MediChoice plan premium. Adults earning between 150 percent and 185 percent of the FPL would receive the full premium amount. Those earning between 185 percent and 250 percent of the FPL would have their tax credits determined on a sliding scale. These MediChoice tax credits would cost an estimated $151.8 billion from 2005 to 2013 ($26.1 billion in 2013) and cover an estimated 3.6 million currently uninsured people.

Workers in small firms who earned below 150 percent of the FPL would receive a credit for the full cost of a standard MediChoice plan, and those who earned between 150 per-

**The Lieberman plan would increase taxes, expand government health programs, create national and state-based health alliances, grant restrictive tax credits, dictate a standard benefits package, and impose mandates on employers.**

cent and 250 percent of the FPL would receive a partial credit. Tax credits would be adjusted to ensure that no eligible person would pay more than 7.5 percent of adjusted gross income on health insurance premiums. A new KeepCare program would grant eligible workers tax credits equal to 65 percent of COBRA or health alliance premiums. These tax credits would cost an estimated $104.9 billion from 2005 to 2013 ($20.3 billion in 2013) and cover an estimated 4 million people.

The Lieberman plan also would provide enhanced tax deductions for firms that extended coverage to part-time and contract workers and would allow individuals to deduct a portion of their long-term care premiums.

***Government Controls.*** Children would be enrolled automatically in MediKids at birth, though parents would have the option of declining coverage for their child. The KeepCare program would require all employer health plans to continue covering workers for two months after they left or lost their jobs. Firms that offered health insurance yet had more than 10 percent of their employees eligible for MediChoice—either because the employee's share of the premium exceeded 7.5 percent of the employee's adjusted gross income or because the coverage did not meet the government standard—would face a penalty: they would be required to pay the federal government's share of premiums for their employees who enrolled in MediChoice.

Insurers participating in the MediKids program would be required to provide a standard benefits package including "comprehensive coverage for preventive care, hospitalizations, prescription drugs, long-term care, all recommended vaccines, and other health care services," as well as government-specified limits on out-of-pocket costs.[59] Both the MediKids and MediChoice programs would control the prices charged and profits earned by, as well as provide reinsurance for, participating insurers. Moreover, "private insurers would have to agree to limit their profits to a small percentage of their costs, while federal reinsurance will protect against catastrophic losses."[60] Insurers participating in MediKids would be required to offer coverage to participating children's families through MediChoice. MediChoice insurers would be required to provide standardized information on plan pricing and benefits, as well as a standard benefits package: "All policies will cover pre-existing conditions, prescription drugs, and provide comprehensive coverage."[61] The standard benefits package would include mental health parity.

The Lieberman plan contains many provisions seen in other plans. The strength of the Lieberman plan is that it would allow children to leave government health programs with a tax credit (essentially a voucher) good for purchasing private coverage. Unfortunately, the credit applies only to children and could be used only toward insurance in a government health alliance, where government sets prices, dictates benefits, determines acceptable profits, and bears all the risk.

**Rep. Dennis Kucinich**

Rep. Dennis Kucinich presents the most detailed proposal for converting America's health care sector to a government-run, single-payer system.[62] The Kucinich campaign estimates that the cost of its plan for national health insurance would be $6.1 trillion during the 2006–13 phase-in period and climb to $1.2 trillion annually in the first year of full implementation (2013).

***Expanding Medicare.*** The Kucinich plan would expand the Medicare program to cover all Americans. The federal government would be the sole payer for all medical goods and services, and private health insurance would be abolished. A new Enhanced Medicare for All program would phase in coverage of the entire population by age group, starting with children in 2006. By 2013 all Americans would be enrolled. The Kucinich campaign estimates that a combination of existing government health spending ($1.1 trillion), a 7.7 percent payroll tax ($917 billion), taxing currently untaxed health benefits ($245 billion), and "existing non-patient revenues" such as "individual donations, foundations, and hos-

**Rep. Dennis Kucinich presents the most detailed proposal for converting America's health care sector to a government-run, single-payer system.**

pital gift shops"[63] would finance the program.

The Kucinich plan would nationalize more than one-seventh of the U.S. economy, diminishing economic growth and the U.S. health care sector's status as a world leader. American patients are already heavily insulated from the cost of medical care. Were the Kucinich plan to make health care "free," individuals would take less responsibility for their own health and demand for medical care would rise even further. Actual costs would outstrip projections, requiring a greater tax increase than proposed. The economic effects of the required tax increase would be severe. Martin Feldstein estimates that financing entitlement spending through payroll tax increases would decrease economic productivity and impose costs on the economy equal to two-thirds of the tax increase.[64] In other words, the Kucinich campaign's proposed $917 billion tax increase could impose an additional, hidden tax of more than $600 billion. The resulting decrease in jobs and wages would make financing the Kucinich single-payer health system even more difficult.

Eventually, government would be forced to look for ways to control costs. Though the Kucinich campaign stresses that administrative costs would be lower under a single-payer system such as Canada's, it is unlikely the Kucinich plan would find any savings here and very likely it would find additional costs. Professor Patricia Danzon has estimated that after accounting for the "deadweight costs" of taxation and moral hazard, the overhead costs of public insurance programs amount to more than 45 percent of claims payments, compared to less than 8 percent for private insurers:

> The rough empirical evidence tends to confirm that overhead costs in Canada, adjusted to include some of the most significant hidden costs, are indeed higher than they are under private insurance in the United States. Although there may well be waste in U.S. private insurance markets, it is attributable primarily to tax and regulatory factors and is not intrinsic to private health insurance.[65]

The search for ways to control costs would inevitably lead to the rationing of care. Kucinich has announced his intent to limit the amount government pays for prescription drugs. Such price controls would make existing drugs less available. Worse, it would reduce the profitability of investing in research and development of new medicines, leading to fewer breakthrough cures.

Patients living under nationalized health care systems routinely experience government rationing. For example, a recent study of Canada's single-payer system found that patients wait an average of 18 weeks for treatment, a 90 percent increase since 1993. Canadians wait longer for treatment than Americans, but not as long as New Zealanders or the British under their single-payer systems. Economists seeking to put a dollar figure on the cost of waiting have estimated it to be as high as $5,600 per patient.[66] Sometimes the cost is much higher; it is commonplace for patients to die waiting for treatment in single-payer systems.[67] The suffering is not distributed evenly. In Canada, "a profusion of recent research reveals that cardiovascular surgery queues are routinely jumped by the famous and politically connected."[68]

Given the current Medicare program's restrictions on purchasing care privately outside the program,[69] it is unlikely that American patients waiting for care would be able to access it with their own resources. They would be in the same situation as many Canadian patients are in today, only with no United States nearby to provide high-quality care to those who are willing to pay.

**Rev. Al Sharpton**

Though Rev. Al Sharpton has not proposed a specific plan for reforming health insurance, he has endorsed amending the U.S. Constitution to create a legally enforceable right to health care.[70] Sharpton has voiced support for a constitutional amend-

**Though Rev. Al Sharpton has not proposed a specific plan for reforming health insurance, he has endorsed amending the U.S. Constitution to create a legally enforceable right to health care.**

ment (H. J. Res. 30), authored by Rep. Jesse Jackson Jr. (D-IL), which reads:

> *Resolved by the Senate and House of Representatives of the United States of America in Congress assembled (two-thirds of each House concurring therein)*, That the following article is proposed as an amendment to the Constitution of the United States, which shall be valid to all intents and purposes as part of the Constitution when ratified by the legislatures of three-fourths of the several States:
>
> ARTICLE
>
> SECTION 1. All citizens of the United States shall enjoy the right to health care of equal high quality.
>
> SECTION 2. The Congress shall have power to implement this article by appropriate legislation.[71]

Sharpton is the only candidate to elevate an entitlement to health care to the level of a constitutional right. Yet amending the Constitution will not avoid the dilemma such entitlements create by granting one person a legal claim on another person's labor. In the case of health care, the entitlement imposes a duty on workers through taxes that reduce their income and a duty on suppliers (doctors, hospitals, drug manufacturers, etc.) by paying them less for their services than they would accept otherwise. At the same time, the entitlement increases the expectations of the entitled; each duty imposed discourages the very behavior—work, curing—that keeps the entitlement's promise.

Granting Mexicans a constitutional right to health care has delivered neither quality nor equality of care. Despite efforts, reflected in the Mexican legislation, to guarantee universal access to health services, the lack of a functional health system, with sufficient human and material resources to effectively respond to the needs of the population, continues to be a fact.[72]

Despite the lower cost of living in Mexico, which makes a fixed income go much further, many American seniors are reluctant to retire to Mexico because of the poor quality of medical care,[73] even though such treatment would be covered by Medicare.[74] As do America's northern neighbors, Mexicans who can afford the expense travel to America for care.[75]

The constitutional guarantee that "all persons are entitled to health protection" has not prevented significant inequality in the way health care resources are allocated by government. During 1999 total per capita expenditure on health (social security and general health services) was only 595 pesos in Chiapas, while it reached 2,299 pesos in Baja California Sur. Overall, Chiapas, Oaxaca, Guerrero, and Puebla had the lowest total per capita expenditure in the country, in spite of having the highest levels of marginality and unsatisfied basic needs.[76] However, America could come closer to achieving equality than Mexico.

The Jackson amendment would compound the entitlement dilemma with its equality mandate. In many single-payer systems, patients have the option of purchasing private health insurance and paying for care out-of-pocket. The Jackson amendment would likely prevent Americans from purchasing care outside a government-run system. Its creation of a right to health care of "equal high quality" could leave Americans in the same situation as many Canadians, who are unable to go outside the public health care system if that system fails to meet their needs.

Whether or not there should be available health services that are fully provided by the private sector, outside the public or mandatory scheme, has been a topic of heated debate in Canada. Many people claim that it is a horrible idea to even consider allowing individuals to attain expedited care outside the rationed public system if they choose to spend their own income to do so. Much of this argument appears to revolve around the concept of egalitarianism: it is often assumed

**Sharpton is the only candidate to elevate an entitlement to health care to the level of a constitutional right.**

**The health care proposals of the Democratic candidates for president in 2004 would further entrench third-party payment and have government assume even greater control over the health insurance consumers purchase.**

that the poor deserve not only better care than their incomes would provide but the same care that the most wealthy in society enjoy. Implicit in this concept is that the wealthy should be forced to consume health care of a lower quality than their incomes would provide. The only standard of care available to anybody should be the standard that can be offered for the entire population.[77]

Scarcity dictates that constitutionally entitling all Americans to the same level of health care would diminish rather than increase health care quality. America's robust trial bar would hasten this race to the bottom by subjecting any inequities to legal challenge. The Sharpton campaign has embraced this eventuality: "If we pass a new health care amendment, the next civil rights movement will emerge fighting for congressional legislation—while also using the federal courts—to implement the Health Care Amendment."[78]

Although Sharpton's health care platform may be the most far-fetched of any of the candidates' proposals, in one sense it is the most responsible. Sharpton is the only candidate who has proposed seeking constitutional authority before granting the federal government greater power over America's health care sector.[79]

## Conclusion

Health care costs and the number of uninsured Americans are rising because of government promotion of third-party payment and the fact that nowhere in America can a consumer purchase a health insurance policy based solely on his preferences and what an insurance carrier is willing to offer. The health care proposals of the Democratic candidates for president in 2004 would further entrench third-party payment and have government assume even greater control over the health insurance consumers purchase. Each would lead to higher taxes, greater health care costs, dampened economic growth, and greater rationing of care. An amalgamation of even the least harmful components of the Democratic presidential candidates' health plans would be a disaster.

Enhancing the quality and affordability of health care requires replacing government's preferences with choice and competition in all aspects of health insurance: point of purchase, pricing, benefits, and regulatory structure. Ideally, government would restore market incentives to private health insurance markets by dramatically lowering tax rates and taxing health insurance premiums and medical expenses like other expenditures. Although such sweeping change is unlikely, forward-looking reforms have begun to chip away at the harmful incentives of the tax exclusion for employer-provided health insurance.

The health savings accounts that take effect in 2004 will for the first time end the federal tax code's bias toward third-party payment. By balancing the tax code's incentives to consume care against a new incentive to save for future medical needs, HSAs will make millions of Americans more value-minded consumers. Consumers demanding greater value will make their preferences known to producers, weed out waste and inefficiency, and help control costs for all health care purchasers, including employers and government health programs. HSAs reflect the lessons learned from decades of government suppression of the market process in the health care sector. Its successes will disseminate that knowledge further. A better approach than any of the Democratic plans would be to do nothing and let health savings accounts transform America's health care markets and culture.

All the knowledge and tools necessary to control costs and improve quality are with us, locked inside the minds of hundreds of millions of consumers. Accessing them requires putting the federal government back within its constitutional restraints by removing the government's preferences from the health care sector—little by little if necessary—and allowing consumers' preferences to direct the market.

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