

28. Health Care

Congress should

- offer a simplified set of flexible medical savings account options to *all* Americans;
- provide a fixed-dollar tax credit option to taxpayers who purchase health insurance;
- expand consumer choices that increase market-based accountability by health plans, instead of enacting a patients' bill of rights; and
- fundamentally restructure Medicare to expand competitive private health plan choices.

Over the past two years, Congress continued to stumble step by step toward enacting President Clinton's vision of government-controlled health care. Although the president once acknowledged that his original plan to radically remake the American health care system with a single piece of 1,342-page legislation might have been dismissed as "too ambitious," he also promised to keep accomplishing his goal "a step at a time, until we finish this."

Since rejecting the comprehensive Clinton plan in 1994, Congress has lacked its own consistent and coherent vision of free-market health care reform. Instead, it has essentially implemented a series of modified versions of the president's downscaled agenda. Those "incremental" health care measures included portability reforms and risk classification limits that expanded federal regulation of private health insurance (1996), federally mandated coverage of mental health and maternity benefits (1996), and a new subsidized insurance program for children (1997).

The 106th Congress moved closer to enacting further regulatory controls and mandates on private health care plans, but it stopped just short of reconciling House and Senate versions of so-called patients' bill of rights

measures. It also moved toward expanding Medicare prescription drug benefits and considered measures to target new tax subsidies to uninsured Americans. While Congress timidly refrained from taking on necessary restructuring of Medicare, private health plan options under the Medicare + Choice program continued to shrink rather than expand. The only sustainable point of consensus in Congress appeared to be that temporary Medicare trust fund surpluses should be sheltered in a mythical “lockbox” and current spending projections left unquestioned.

On the bright side, the last Congress did adjourn without actually making those latest sets of proposals law. More troubling, the federal government remains poised to assume even greater control over the U.S. health care system.

The next Congress needs to reverse course and begin to restore fundamental control of health care decisionmaking to individual consumers within a competitive free market.

Medical Savings Accounts

One of the major factors driving health care costs higher has been the increasing share of medical bills paid by third-party payers such as private health insurers, employers, and government agencies. On average, more than three of every four dollars used to purchase health care are actually paid by someone other than the consumer who incurs the bill.

The centerpiece of market-oriented health care that can reverse this trend remains medical savings accounts (MSAs). MSAs combine two elements—a savings account controlled by an insured individual to pay for routine health care expenses along with a high-deductible (catastrophic) insurance policy to cover more substantial health care needs. With MSAs, a much smaller share of health care spending is funneled through third-party insurance. Individual consumers directly control more of the money.

The premium savings gained by switching to catastrophic health insurance can be redirected to a worker’s individual account. The worker then can use the MSA funds to pay medical bills below the insurance deductible amount. The MSA funds can be used for whatever medical services or treatments the worker chooses, including items not ordinarily covered by the accompanying insurance policy. Any account funds that are not spent on health care can be saved, or they can be withdrawn for other purposes.

MSAs provide workers strong market incentives to control the costs of their health care, because account holders are effectively spending their own money for routine health expenses. That, in turn, stimulates real cost

competition among and price disclosure by doctors and hospitals. Health care providers seeking more business must offer high-value services that minimize cost and maximize quality.

Although Congress has in recent years launched several limited experiments involving MSA options, the results have been disappointing. The 1996 Health Insurance Affordability and Accountability Act (HIPAA) authorized up to 750,000 “tax-qualified” MSAs over a four-year period. Unlike previous MSAs, HIPAA accounts featured tax-deductible treatment of MSA deposits and tax-exempt treatment of investment earnings accumulated within the MSAs. The Balanced Budget Act of 1997 included a new Medicare + Choice coverage option that allowed up to 590,000 Medicare recipients to participate in private MSA health plans.

Both experiments were full of design flaws that prevented them from succeeding. By limiting the number and type of MSAs available, Congress diminished the normal market incentives for insurers to market the product and consumers to buy it. Congress compounded the problem by restricting eligibility for MSAs to only a small portion of the insurance marketplace. As a result, fewer than 100,000 “tax-qualified” MSAs have been opened since 1996, and not a single Medicare MSA plan has been offered to seniors.

The next Congress needs to consider a new set of simplified MSA options that would make MSAs available to *all* Americans. Market-oriented MSA rules would provide much more flexibility in deductible levels, contribution amounts, and withdrawal options. The best way to bring down health costs and improve health care quality remains a simple one—let workers and patients control more of their own health care dollars.

Tax Equity and Efficiency

MSAs provide a foundation for free-market health care reform, but Congress needs to enact more fundamental changes in the tax treatment of health care benefits. The tax system should promote economic efficiency and be perceived as fair. Its compliance and administrative costs should be kept to a minimum. Tax policy proposals that try to target more narrow objectives must be structured to reinforce, not undercut, those fundamental principles.

Current federal tax exemptions and deductions for health care spending reduced federal reserves by an estimated \$126 billion in 2000. Employment-based health insurance benefits claimed nearly all of those tax subsidies (\$121 billion). Federal tax law excludes the cost of employer-spon-

sored health insurance benefits from the taxable income of individual workers, and it also excludes them from Social Security and Medicare payroll taxes. Many employers also offer their employees tax-exempt flexible spending accounts for health care reimbursements.

However, those job-based tax benefits for health care spending put employers, instead of employees, in charge of selecting health care benefits. Special tax treatment of employer-sponsored group insurance via the so-called tax exclusion forces many working Americans to accept the only health plan offered by their employer, or pay higher taxes. According to the Center for Studying Health System Change, about 64 percent of working families who are offered employer-sponsored insurance have a choice of health plans. Only 49 percent of families offered employer-sponsored coverage can choose between a health maintenance organization and a less-restrictive health plan.

The tax exclusion also raises the comparative after-tax price of other non-employer-based insurance alternatives. Although somewhat smaller tax subsidies are available to the self-employed, the tax exclusion provides no assistance at all to other individuals (such as Americans working in firms that don't provide health insurance) who might wish to purchase health insurance on their own. At best, the latter may take an income tax deduction for only the portion of their personal health care expenses that exceeds 7.5 percent of their adjusted gross income.

The tax exclusion distorts health care purchasing choices by favoring the financing of medical services through insurance and providing the greatest tax benefits for the most costly versions of employer-sponsored coverage. It encourages workers to think that someone else (their employer) pays for their health care, and it reduces their sensitivity to the cost of health insurance choices. Individual workers therefore seek the most comprehensive versions of such coverage available, instead of using more of their own funds to pay for health care as they receive it. The tax exclusion disconnects the consumption decisions of insured workers and their families from the payment decisions of employers and their insurers. Employer-sponsored insurance policies are more likely to reflect the financial concerns of employers than the particular preferences of individual employees.

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

The best way to remove tax policy distortions in the health insurance market would be to eliminate tax subsidies for employment-based health

insurance altogether. However, repeal of the tax exclusion would need to be accompanied by offsetting reductions in marginal income tax rates and raising the income tax bracket thresholds, in order to minimize economic distortions and return the money to American workers. A sudden, total removal of the tax exclusion also would harm workers who chose jobs partly on the basis of the after-tax value of the health benefits package offered by competing firms.

Implementing a flat income tax or a national sales tax provides the best comprehensive solution. Fundamental tax reform would render neutral the federal government's tax treatment of all goods and services, including health care. Absent a broad restructuring of the tax code, the next-best policy would be to encourage workers to voluntarily trade in their tax exclusion subsidies under the current system in return for a fixed-dollar tax credit. The tax credit would not discriminate against people who purchase health insurance individually or through non-employer-based groups. It could be used to pay for all health care services, whether financed through insurance or paid out of pocket.

However, the tax credit option should be contingent on the purchase of at least basic catastrophic insurance coverage. As a voluntary alternative to the existing tax exclusion, tax credits would provide individuals much greater freedom to purchase health insurance and health care in the way that best meets their needs.

Individuals still could choose to apply their tax credit funds toward the purchase of any particular type of group insurance offered by their current employer. They also would be able to use the tax credit to help purchase insurance from other sources. Or they could combine it with more of their own after-tax dollars to buy more expensive insurance coverage.

For many Americans, the most valuable use of the tax credit would be to purchase high-deductible catastrophic insurance and combine it with after-tax contributions to an MSA. At a minimum, investment earnings on this kind of after-tax MSA contribution should remain tax deferred until they are withdrawn. Ideally, the tax treatment would be even more generous and similar to that of a Roth individual retirement account, with no further taxes on the buildup and subsequent withdrawals of savings that have been accumulated and invested for a sufficiently long period of time. Personal choices between spending MSA savings on health care or other goods and services then would be driven by their comparative value to consumers, rather than their respective tax advantages.

The tax credit option also could help speed the future transition for many employers from offering only defined benefit health care plans to

providing a broader menu of choices within defined contribution plans. Under defined benefit plans, employers promise to cover one or more fixed sets of health services, in the amount and manner they determine. Defined contribution plans would essentially convert health benefits promises into cash, with fixed contributions made to each employee. Employers might continue to sponsor some particular health plan choices and provide information about others, but the final choice of health plan would be placed in the hands of employees who would directly control their defined contribution payments.

A thus far underused portion of the Internal Revenue Code allows an employer to extend the advantages of the current tax exclusion to defined contribution arrangements. The employer may choose to reimburse employees for some or all of the health insurance premium expenses they incur when employees select health plans that are *not* sponsored by the employer. However, this defined contribution remains tax advantaged only if the employer makes premium reimbursement payments *directly* to the employee's insurer, without the money passing through the employee's hands.

A recent study by Booz-Allen & Hamilton concluded, "A large-scale conversion of employer-sponsored health plans to defined-contribution formats is inevitable." Further clarifying the tax treatment of employers' defined contribution payments and removing other regulatory uncertainties would accelerate the move to an employee benefits environment in which workers more directly control their health care benefits and insurance choices.

A fixed-dollar tax credit option could jump-start this process by ensuring sufficient consumer demand for individually selected insurance arrangements and providing a competitive alternative to employer-sponsored group insurance. Requiring employers to report the amount of their contributions for an individual employee's health coverage would help as well. That information would sensitize workers to the full cost of their health insurance benefits and allow them to compare the tax exclusion value of employer-sponsored benefits with the amount provided by a fixed-dollar tax credit option.

The default setting for reporting employer contributions on an annual W-2 would assume that workers in employer group plans are community rated *within* the firm, and the employer contributions for insurance coverage would be identical for each worker. In the event that employers were allowed to adjust health plan contributions to reflect factors specific to

individual workers (relatively difficult to do under current law), they could report those differing amounts instead.

The individual tax credit should be big enough to help workers and their families purchase insurance that covers large medical expenses, but small enough to encourage them to save more money to handle out-of-pocket payments for smaller health care costs. The tax credit should not try to finance comprehensive insurance for all uninsured, low-income Americans. A poorly designed, overgenerous tax credit would artificially boost health spending levels, refuel health care inflation, increase budgetary pressures, and set off new rounds of misguided measures to control its costs (e.g., complex income-based, phase-out levels; tight restrictions on the contents of eligible health benefits packages; and federal rules for eligible insurers).

Expanded subsidies always threaten to lead to more regulation, followed by more efforts to evade regulation and then renewed calls for more regulations. The more the federal government pays for something, the more it will want to control it. Capping the size of individual tax credits would keep this danger in check and also help maintain market-based price signals at the margin for health care consumption choices.

Making the optional tax credit refundable for workers without sufficient taxable income to offset its full amount would further blur necessary policy distinctions between expanding income-based welfare assistance and neutralizing the many distortions caused by our complex tax system. Tax relief should be limited to people who actually pay taxes. It should not be used as a subterfuge for income redistribution or delivery of expanded health care benefits to targeted segments of the population. For low-income individuals, the better policy solution would be to (1) offer them a health insurance voucher as an alternative to Medicaid coverage of equivalent value and (2) reverse regulatory policies that increase the cost of their health insurance and health care services.

Managed Care and Consumer Empowerment

Although the growth of managed care insurance coverage during the last decade helped to restrain the rate of growth of health care costs, consumers increasingly are dissatisfied with managed care's limits on covered treatments and restrictions on their choice of physicians. Various congressional "patients' bill of rights" proposals constituted the primary political responses to those cost and quality conflicts. Such legislation would mandate coverage of various health services, require insurers to

collect and dispense more specific information about their operations, and pile more regulatory edicts on an already overly regulated industry. Congress should call a halt before it further politicizes complex health care decisions, raises costs, restricts choices, and reduces private insurance coverage levels.

The politics of managed care regulation reflects a growing sense of disempowerment by consumers who believe that they have little control over their health care. Provider interest groups encourage the growing perception that current choices are illusory or unfair. But the valid concerns behind the managed care backlash can be addressed with more fundamental, market-oriented remedies—instead of centrally prescribed political standards.

Empowering health care consumers must begin with greater tax equity and new voluntary pooling options to provide a more level playing field for workers who prefer alternatives to their employers' group health plans. The various tax reforms noted above (fixed-dollar tax credits, defined contribution plans, fundamental tax reform) would help employees to regain control of their health care benefits funding and to switch insurance policies if they become dissatisfied with a particular employer plan.

Unfortunately, risk pools formed outside large firms and solely for the purchase of insurance tend to be less stable, more heterogeneous at entry, and less likely to be replenished with low-risk individuals. Congress should respond by facilitating new risk pooling devices and refining previous proposals for HealthMarts and association-sponsored health plans, to enable small employers and their employees to shop for additional insurance options at a lower cost. Sponsors of new voluntary purchasing arrangements should be allowed to use economic incentives, risk classification techniques, and multiyear commitments to keep a sufficient number of participants in their risk pools. New pooling options should not be limited to just business group buyers; they should be open to individual purchasers as well.

Current levels of health plan disclosure can be enhanced more effectively through competition for consumers who are free to take their business elsewhere than through a one-size-fits-all set of politicized disclosure regulations. But asking consumers to be more responsible also means that managed care insurers and self-insured employers will need to accept more accountability. Plan sponsors and administrators should be held legally responsible for their representations to plan subscribers.

Liability rules should clarify the differences between contractual obligations (delivering what is promised within the written terms of a health

insurance policy) and tort liability (providing compensation for personal injuries and other losses arising from care rendered by health care providers under the contract between a health plan and a purchaser of its coverage). Recent court decisions are beginning to draw necessary distinctions between coverage decisions by administrators of a health plan's terms (the health insurance role, determined by contract) and medical treatment decisions by overseers of the plan's health care quality (the medical provider role, subject to tort liability).

Congress has remained stalemated over how to hold managed care plans more accountable for negligent medical treatment decisions but avoid crushing them under an avalanche of personal injury lawsuits. Legislative proposals setting rules for external review safeguards might limit liability risks and litigation costs, but their applicable standard of review for coverage decisions should focus on interpreting and enforcing the actual contractual terms of a particular health plan—rather than making *de novo* “expert” judgments on what constitutes “medically necessary” treatment according to a uniform standard of care.

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

Medicare

Even with recent improvements in its short-term financial outlook, Medicare remains progressively unsustainable on a long-term basis. The 1997 Balanced Budget Act achieved some modest savings through arbitrary price controls and regulatory uncertainty, but it severely damaged private competitive insurance alternatives to the traditional Medicare program. Congress must begin dealing honestly with the entitlement crisis. Future demographic pressures alone will challenge Medicare's financial resources, and the traditional program structure remains ill equipped to head off the return of escalating growth in real spending per beneficiary. Artificial calculations of Medicare's Hospital Insurance (HI) trust fund's date of insolvency fail to capture the overall economic reality of higher taxes ahead under an unreformed Medicare program. The HI program (Part A) remains substantially out of long-range financial balance; the Supplementary Medical Insurance (Part B) side of Medicare will continue to grow faster than the overall economy. Working Americans remain on the hook for a rising share of the imminent cost explosion. As long as

Medicare remains one of the most volatile and uncontrollable programs in the federal budget, its unrestrained appetite will squeeze out other national priorities and jeopardize opportunities for future generations.

Moreover, simply preserving the current Medicare program, without substantial improvements and structural change, would ignore the needs of current and future beneficiaries. Medicare's basic benefit package has become increasingly outdated and inflexible. Traditional coverage fails to protect seniors against catastrophic medical bills. Many coverage and reimbursement issues face inefficient, interminable, and inconsistent administrative determinations.

The 1999 bipartisan commission on Medicare offered a number of promising reforms, but further actions to follow up on them and overhaul Medicare languished in Congress. Instead, Congress put the restructuring debate in a rhetorical lockbox and focused on expanding the Medicare entitlement to include prescription drug coverage.

The next round of Medicare reform should emphasize structural reforms above short-term budget savings targets. The bungled experiment in Medicare + Choice must be repaired. Congress should eliminate the uncertainties and excesses of its complex regulatory requirements, time limits, and payment methodologies. A sustainable framework for Medicare modernization requires moving from an antiquated defined benefit structure to a defined contribution, premium-supported model, under which seniors could choose among competing packages of health benefits with taxpayers' costs capped at preset levels. Healthy competition would force the traditional Medicare fee-for-service coverage program to improve and fight for market share on a level playing field. Seniors seeking additional supplemental benefits would pay additional premiums reflecting their marginal costs. Medicare beneficiaries who accepted greater individual responsibility would be rewarded with broader health coverage choices and possible cash rebates.

Scrapping the bizarre world of politically driven Medicare price controls will require that defined contribution payments be determined by competitive market prices. Competitive bidding mechanisms and reasonable ground rules for periodic open enrollment choices offer great promise for ending distorted prices and poor information. Once those tools set the proper foundation, vigorous competition among health plans will hold down costs much more effectively than explicit regulation of prices or premiums.

Adding prescription drug benefits to Medicare should accompany, not precede, such structural reform. An updated Medicare + Choice program

and a restructured version of traditional Medicare could offer a range of enhanced drug benefits options to beneficiaries willing to pay for them. Simply dispensing a thin layer of visible, first-dollar subsidies to *all* Medicare beneficiaries regardless of need will follow the same old dead-end path to the Medicare money pit. It will stimulate demand with irresponsible promises, trigger an explosion of benefit costs, resort to price controls and regulations that ration the supply of medical treatment, chill future innovative research, and ultimately snuff out the next round of life-saving drugs.

A better interim policy option is to target the primary gaps in current prescription drug coverage by extending subsidized coverage of prescription drugs to lower-income Medicare beneficiaries not eligible for Medicaid and mandating protection against *catastrophic* drug costs in a revised set of more flexible Medigap supplemental insurance options. Integrating drug benefits into various sets of competitive medical benefits packages is far superior to contorted efforts to subsidize drug-only insurance alternatives.

Fundamental Medicare reform also would scrap the mirage of trust fund financing, particularly the arbitrary shell game distinctions between the Part A HI fund (financed by payroll taxes) and the Part B SMI fund (financed approximately 3/4 by general revenues and 1/4 by beneficiary premium payments).

An initial round of intermediate reform measures would help realign the current Medicare structure to allow its later transformation into a fully privatized system of health care choices for seniors. In moving first to get the basic structure right, Congress should give careful consideration to eventually making it possible for younger workers to divert some or all of their Medicare payroll taxes into savings vehicles that would prefund their purchase of private health insurance when they reach retirement age. Transitional finance issues may slow the evolution toward this ultimate objective, but a full return to individual responsibility and private-sector health care offers the only long-term hope for surmounting the perennial financial crises and bureaucratic morasses of Medicare as we know it.

Conclusion

We cannot afford to let the market vision of health care reform be dimmed by cut-rate compromises leading to a slow, steady drift toward centralized, politicized control of health spending decisions. Every calculated attack on private health insurance markets should be resisted, before

a series of “small” proposals steadily accumulate to make private coverage ever more expensive and difficult to obtain.

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

Suggested Readings

Blevins, Sue A. “Restoring Health Freedom: The Case for a Universal Tax Credit for Health Insurance.” Cato Institute Policy Analysis no. 290, December 12, 1997.

Ferrara, Peter. “The Next Steps for Medicare Reform.” Cato Institute Policy Analysis no. 305, April 29, 1998.

Goodman, John, and Gerald Musgrave. *Patient Power: Solving America’s Health Care Crisis*. Washington: Cato Institute, 1992.

Miller, Tom. “Nickles-Stearns Is Not the Market Choice for Health Care Reform.” Cato Institute Policy Analysis no. 210, June 13, 1994.

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

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

Tanner, Michael. “Medical Savings Accounts: Answering the Critics.” Cato Institute Policy Analysis no. 228, May 25, 1995.

———. “What’s Wrong with the Present System.” In *Empowering Health Care Consumers through Tax Reform*. Edited by Grace-Marie Arnett. Ann Arbor: University of Michigan Press, 1999.

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