



Backgroundunder

Executive Summary

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TOP TEN WAYS TO FIX AMERICA'S HEALTH INSURANCE MARKET AND EXPAND COVERAGE

JAMES FROGUE

President George W. Bush and the 107th Congress face important decisions about how to fix America's health care system so that all Americans have access to quality health insurance coverage. Today, approximately 42 million people go without coverage at some point during the year, and experts predict this number will rise.

Policymakers must begin to think "outside the box" and look for solutions beyond the employment-based health insurance system that is a relic of the World War II era. The current system provides tax benefits for those who purchase insurance through their employers but no incentives for people who do not have access to employment-based plans. Without reform, the uninsurance trend will continue to rise in today's dynamic information-driven economy that puts a premium on mobility. But it will accelerate even faster if the economy enters a recession or if Congress passes so-called patients' rights legislation and imposes a new level of detailed regulation and mandates on the market, raising costs and expanding liability for employers.

Congress and the Bush Administration must work together to ensure equity in the tax code for those who do not have access to employer-based coverage. Providing the resources alone, however, will not be enough. Congress must also pave the

regulatory way to empower individuals, families, and groups other than employers to make their own health care decisions and purchase insurance to fit their needs. The 10 steps discussed in this report offer policy-makers ways to make sound improvements in the current system that will greatly expand accessibility, coverage, and choice. Specifically, they should:

- 1. Provide tax credits for the purchase of health insurance.** The most recent research, conducted by Mark Pauly and Bradley Herring of the University of Pennsylvania's Wharton School of Business, indicates that a tax credit equal to 50 percent of premiums would reduce the number of uninsured by half. The tax credits should be fully refundable, pre-payable, and made available to all Americans.

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2. **Clarify the liability of employers who offer defined contributions.** Employers have moved from offering defined benefits to providing defined contributions in retirement accounts, and many would like to do the same with health benefits. Congress should make plain in statute that by giving their employees control of the plans in this way, employers would be free from fiduciary responsibility.
 3. **Allow employees to make tax-free contributions to their health plan.** Congressional staffs now enjoy this perquisite. Surely, private-sector workers should enjoy the same benefit.
 4. **End the caps on medical savings accounts (MSAs).** Congress should lift the restrictions on MSAs so that individuals can participate regardless of employment status or size of employer.
 5. **Permit the formation of association health plans (AHPs).** Allowing owners of small businesses to band together across state lines to increase their purchasing power or to self-insure and spread the risks would enable them to offer or improve health plans for their workers.
 6. **Allow individual membership associations (IMAs) to offer health insurance.** Like AHPs, IMAs could leverage the buying power of members of fraternal, religious, or professional associations. Because people tend to be members of such groups much longer than they tend to work for one employer, members of IMAs could enjoy continuity of coverage regardless of job mobility.
 7. **Allow health care consumers to choose between plans covered by federal or state regulations.** Congress should amend the Employee Retirement Income Security Act of 1974 (ERISA) so that a plan purchased with an employer's defined contribution need not be considered a group plan as is now the case. A group plan brings with it certain federal regulations, whereas individual plans are regulated by the state. If employees could choose the regulatory framework behind their plans, they are more likely to be satisfied.
 8. **Encourage responsible buying of insurance.** Congress should eliminate the "guaranteed issue" provision in current law, which mandates that insurance companies and HMOs selling in the small group market must sell insurance to any employer regardless of the employer's claims history or employee health. This encourages employers to buy coverage only when employees need it, which is similar to purchasing homeowners' insurance after the house burns down.
 9. **Consider creating a new federal charter for health insurance.** The current morass of federal and state regulation is confusing and often duplicative. Congress should examine the feasibility of creating a new federal charter for health insurers and consumers. Consumers could participate in this new option or in their state-regulated systems, much as people today can choose to save in a federal- or state-regulated bank.
 10. **Promote a national high-risk pool for the highest-cost, most vulnerable people—the "uninsurables."** A national high-risk pool should be part of the federal charter so that people who are turned down by an insurer can still obtain coverage. Although "uninsurables" represent as little as 1 percent of the population, their needs are the greatest and must be accommodated.
- By focusing on strategies such as these, the Bush Administration and Congress can reverse the growing numbers of Americans without health insurance and make today's health insurance system reflect the needs of families in today's rapidly changing economy.
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TOP TEN WAYS TO FIX AMERICA'S HEALTH INSURANCE MARKET AND EXPAND COVERAGE

JAMES FROGUE

President George W. Bush and the 107th Congress inherited a problem from their predecessors that they will be unable to ignore: how to fix America's troubled health care system so that every American gains access to quality health insurance coverage. Today, an estimated 42 million people go without insurance coverage at some point during the year, and experts predict that—without policy changes and reforms in today's employment-based system of coverage—this number will continue to rise.

Surprisingly, policymakers have one advantage in finding a solution soon: Fixing America's health care system is not a partisan concern. A number of bills introduced in the 106th Congress by Members of both parties sought to improve health insurance for all Americans. To the extent that those bills merely build on the current system, however, they are unlikely to succeed. If legislators and policymakers want to greatly expand access to health insurance and drastically reduce the number of Americans who go without private coverage, they must begin to think "outside the box."

The current system—a product of the World War II era—is badly fraying. It needs an injection of innovation to stimulate market forces like choice, flexibility, and accountability that will lift the quality of care and the availability of coverage.

Such solutions must, therefore, be rooted in these principles:

- **Tax Fairness.**

Rather than relying on today's tax-biased system that ties coverage to employers, policy-makers should make fully refundable, pre-payable tax credits also available so that all Americans have access to health coverage.

- **Market Expansion.** Rather than

limiting people to the plan(s) their employers select, policymakers should stimulate the market by amending current law to allow alternative pooling arrangements, permitting people to buy coverage from groups with which they associate and identify, such as trade associations, church groups, and fraternal organizations.

- **Deregulation of Medical Savings Accounts.** Rather than crippling medical savings accounts

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(MSAs) with statutory and regulatory restrictions, policymakers should find ways to lift the cap on MSAs and enable more Americans to use them to purchase the health care they need.

- **Personal Choice.** Rather than relying on defined benefits, policymakers should craft a system based on tax credits and defined contributions to increase consumer choice in the health market. They also should reduce the regulatory burdens imposed on consumers that limit their ability to buy health insurance. Such a system would allow consumers to choose a plan that fits their needs in the same way they buy auto, homeowners, and life insurance.
- **New Rules of the Game.** Rather than perpetuating a health insurance market that is a complex maze of federal and state regulations, with confusing overlap and duplication that drives up health care costs, Congress should examine the feasibility of creating a new federal charter that sets limited solvency requirements and underwriting standards for the industry without encroaching on the ability of insurers to create benefit packages or of consumers to buy the plans of their choice.

For a variety of reasons, increasing numbers of Americans must go without coverage or try to buy coverage independent of their employment. This trend will persist, largely because of changes in the dynamic information-driven economy that puts a premium on mobility. But it will accelerate if the economy enters a recession and employers are forced to drop coverage, or if Congress passes so-called patients' rights legislation that imposes a new level of detailed regulation and mandates on the market, raising costs and expanding liability for employers.

Washington should restore some semblance of equity to the tax code so that lower-income workers receive the same tax treatment higher-income workers now enjoy. Providing resources alone, however, will not be enough. Congress must pave the regulatory way in order to empower individuals, families, and groups other than employers to make health care decisions and purchase insurance that fits their needs. Congress will also need to amend the Employee Retirement Income Security Act of 1974 (ERISA)¹ to create another category of health plans called "association health plans." Policymakers who want to make sound improvements in the current system should adopt a blueprint for reform that includes changes that reflect both an understanding of the root causes of uninsurance and an appreciation of market forces that increase accessibility, coverage, and choice of health coverage.

THE GROWING PROBLEM OF THE UNINSURED

According to the U.S. Bureau of the Census, 42.6 million Americans under the age of 65 had no health insurance at some point during 1999.² There is some disagreement as to the exact size of this population of uninsured, but virtually all experts forecast that the number will rise in the coming years.³

In a recent study conducted for the Health Insurance Association of America (HIAA), for example, William S. Custer and Pat Ketsche of the Center for Risk Management and Insurance Research at Georgia State University estimated that the number of uninsured will rise to 48 million by 2009. Assuming rapid economic growth combined with rapid health care cost inflation, that number could reach 55 million by 2009. In the event of a

1. USC 29, Sec. 1002. ERISA regulates, controls, and affects nearly all employee benefits in the private sector, including employer-sponsored insurance plans.
2. U.S. Bureau of the Census, at <http://www.census.gov/hhes/hlthins/hlthin99/hlt99asc.html>.
3. During a December 7, 1999, Heritage Foundation conference for congressional staff, John Shiels of the Lewin Group stressed that the actual number of the uninsured may be significantly overstated by the official U.S. Bureau of the Census tabulation. The reason: Too many Americans on Medicaid have reported erroneously that they have no insurance, and many are covered by other programs; moreover, illegal aliens are often counted in official estimates.

recession, 61 million Americans could be without coverage at the end of this decade.⁴

Estimates differ, but other major studies also point generally to a rising number of uninsured. For example, the National Coalition on Health Care estimated in May 1999 that the number of uninsured Americans could climb to 61.4 million by 2009,⁵ while the Virginia-based Lewin Group, a leading econometrics consulting firm, projected in June 1999 that the number of uninsured would reach 54 million by 2007.⁶

Rising Costs. The reason for the high number of uninsured and the projected increase in the number of uninsured is, quite simply, ever-higher costs. As health insurance becomes more expensive, fewer employers are willing and able to provide coverage for their employees. Indeed, “cost” was cited by small employers as the number one reason they do not offer coverage to their employees.⁷

Small businesses (with one to 49 employees) account for 94.7 percent of all businesses in the United States and employ 41.5 percent of the workforce.⁸ In 1999, 40 percent of these businesses did not offer health insurance coverage to their employees.⁹ As premium costs continue to rise well beyond the rate of inflation, more Ameri-

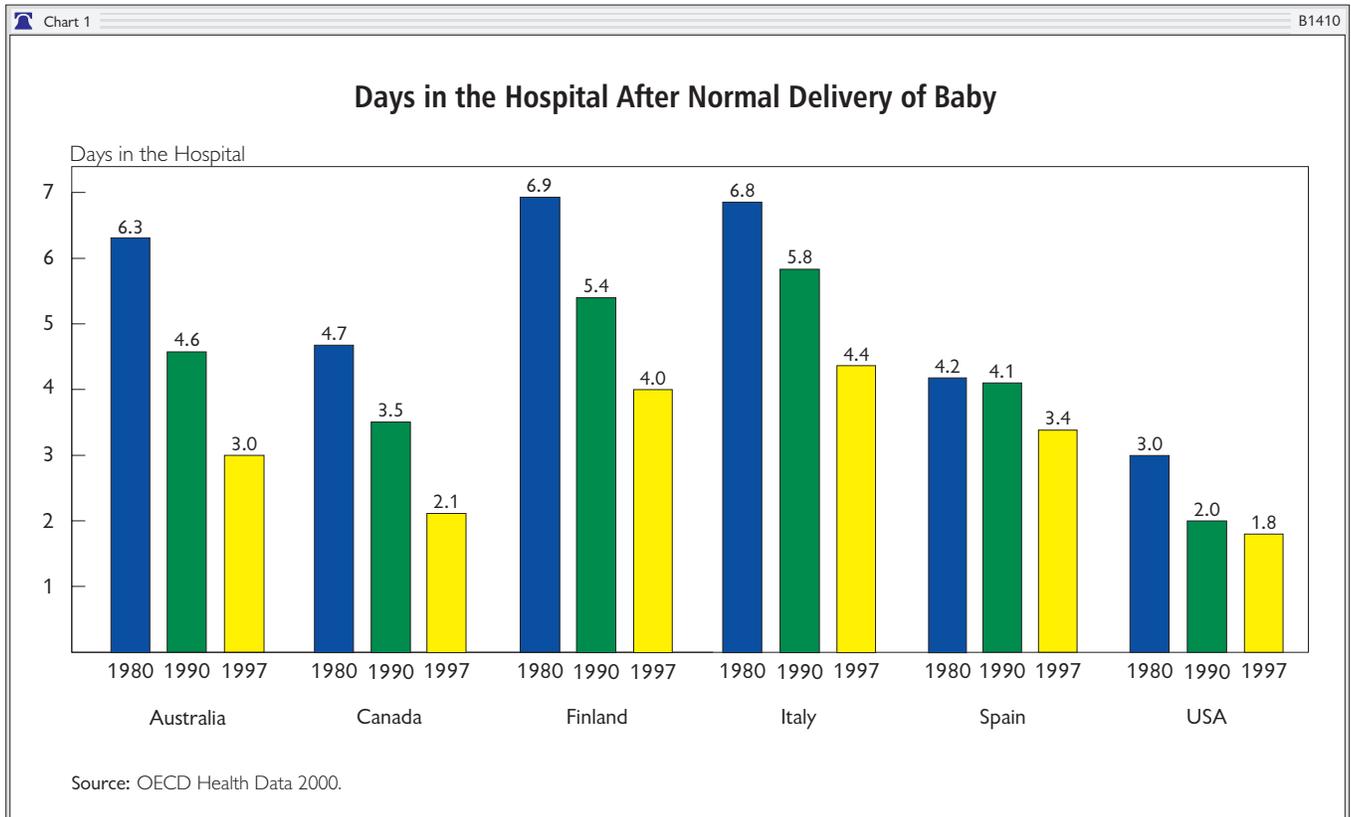
cans—and particularly those who work for small businesses—will become uninsured. A summer 2000 survey of 500 employers with fewer than 150 employees found that 11 percent said they would no longer offer health insurance if premiums rose 5 percent to 9 percent in the coming year.¹⁰ A recent analysis performed by C. T. Hellmuth and Associates, based on an examination of 2,000 health plans in 139 markets across the United States, projects average premium increases of 10 percent to 13 percent in 2001.¹¹ Research conducted by the actuarial firm of Milliman & Robertson has led to similar predictions.¹²

Continued rising costs are driven by many factors, but most especially by:

- **Over-consumption** of health care services due to the lack of accountability in the third-party payer system, and
- **Government mandates** on the market.

In a third-party payer system, an insurance company (or any payer who is not the patient, such as the government, an employer, or an insurance company) covers most of the cost of medical services. This is the prevailing payment system in America. Such a structure encourages inefficient use of health care services by patients, because they are shielded from the true costs of those

4. William S. Custer, Ph.D., and Pat Ketsche, Ph.D. and M.H.A., “The Changing Sources of Health Insurance,” December 14, 2000, at <http://membership.hiaa.org/pdfs/2000CusterFour.pdf>.
5. Steven Findlay, M.P.H., and Joel Miller, M.S.Ed., “Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States,” National Coalition on Health Care, May 1999; see <http://www.americashealth.org/releases/erosion.html>.
6. Lewin Group analysis of 1998 Current Population Survey data. See John Shiels, testimony before Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 106th Cong., 1st Sess., June 15, 1999.
7. “2000 Small Employer Health Benefits Survey,” co-sponsored by the Employee Benefit Research Institute (EBRI), Blue Cross Blue Shield Association, and Consumer Health Education Council and released at the National Press Club, Washington, D.C., on September 5, 2000. Firms with from two to 50 employees were included in the survey. See <http://www.ebri.org/sehbs/index.htm>.
8. U.S. Bureau of the Census, “1998 County Business Pattern Data,” Table 2, at http://tier2.census.gov/cbp_naics/index.html.
9. Larry Levitt *et al.*, *Employer Health Benefits: 1999 Annual Survey* (Menlo Park, Cal., and Chicago, Ill.: Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 1999).
10. Health Care Leadership Council, “Small Business Health Insurance Survey of 500 Employers,” conducted June 27–July 13, 2000; available at http://www.hlc.org/Making_News/THE_National_Priority/Polling_Data/polling_data.html.
11. C. T. Hellmuth and Associates, *Executive Newsletter* No. 253, Chevy Chase, Maryland, December 2000, p. 2.
12. Milliman & Robertson, Inc., September 30, 2000, published in *Medical Benefits*, Vol. 17, No. 23 (December 15, 2000), p. 1.



services. If an insurer will pay for 10 physical therapy sessions that include a nice massage, it is small wonder that patients will go for all 10 sessions, even if they are significantly healed after five or seven. The cost of this excess use must necessarily be spread out among everyone in that insurance plan.

The tendency to over-consume services in the third-party payer system was confirmed in a large social science study conducted by the RAND Corporation from 1974 to 1982. RAND studied the medical spending habits of 2,757 families (a total of 7,703 persons) in six U.S. cities. The families were placed in four different insurance plans, the most generous covering all medical expenses. The least generous required 95 percent co-insurance up to a \$1,000 maximum. The RAND researchers concluded from the findings that:

- The “use of medical services responds unequivocally to changes in the amount paid out-of-pocket,” and
- “The average person’s health changed very little, despite the rather large change in use caused by the insurance plans.”¹³

The other major driver of costs is the number of mandates placed on health insurers—a particular coverage benefit that either state or federal law requires them to include in plans. Examples of common mandates include forcing insurers to offer coverage for chiropractic services, in vitro fertilization, mental health parity, and treatment for drug and alcohol abuse.¹⁴

Mandates represent nothing more than politicians compelling employers and health care consumers to purchase particular benefits. If the same mindset were applied to the construction of new homes, it would be like lawmakers mandating that

13. For a summary of the RAND study findings, see Joseph P. Newhouse, “Cost Sharing for Medical Care Services,” testimony before the Subcommittee on Defense of the Committee on Appropriations, U.S. Senate, June 12, 1984.

14. This is a limited list.

all houses be built with 12-foot ceilings and a swimming pool. Of course, not everyone can afford such features, and more important, not everyone wants them.

A typical mandate dispute concerns the length of hospital stay for mothers and newborns after delivery. Some states recently have mandated that all plans guarantee a 48-hour hospital stay, even though a 48-hour stay is not necessary in all cases and providing it to everyone when it is sometimes not needed raises costs for everyone. In 1980, the average length of stay in the hospital for American mothers and their newborns was three days. If the 1980 average of three days were mandated back in 1980, any attempt to reduce or eliminate it today would meet intense opposition from hospitals specializing in maternity care.¹⁵ Yet a general decline in the length of hospital stay after childbirth has been occurring in all 29 countries of the Organisation for Economic Co-operation and Development (see Chart 1).

Mandates lock in today's benefits. This decreases the flexibility of plans to incorporate the most up-to-date medical technology and services. Mandates also reduce the incentive for providers to come up with those advances. The effects of mandates and regulations on health care costs are clear. From 1990 to 1994, 16 states were the most aggressive in passing laws designed to increase access to health insurance for their uninsured citizens. These laws included mandates and various regulations on the market. *By 1996, the average annual growth in the uninsured population in those 16 states was eight times higher than in the remaining 34 states.*¹⁶

The way to tame ever-increasing health care costs is twofold:

- **Return** the rationing of care to individuals and families and remove it from third-party payers, except in the case of unpredictable and costly catastrophic injuries or illnesses.

- **Have** states and the federal government permanently extricate themselves from the business of placing mandates on insurers. Let consumers of health care make the decisions as they do in every other sector of the economy.

THE GROWING POPULARITY OF CHOICE

Employers are starting to look more favorably upon the concept of making defined contributions to their employees' health care, just as many now contribute to their employees' 401(k) retirement plans, and more policymakers are looking at tax credits for those who do not have employment-based coverage.

Defined Contributions. In a system that allows defined contributions, employers would designate a specific amount of money for their employees' health care and let the employees use this money to purchase the health plan of their choice. The money would continue to be treated as tax-free income to the employee and a deduction for the employer, free of FICA taxes.

The benefits of such a system are significant. Specifically:

- **Employees** would be free to choose a plan that fits their needs from a universe of options, rather than accept only the plan(s) their employer chooses to offer.
- **Employers** would no longer have to select the plan(s) for their employees, would be relieved of fiduciary responsibility, and would have more predictable health care costs.

Several recent studies by leading consulting companies confirm the rising interest among employees and employers in participating in a system based on defined contributions. For example, after surveying 31 of *Fortune* magazine's "100 best companies," Booz-Allen Hamilton concluded that "Over the next ten years, employer-sponsored health plans will evolve en masse into defined

15. Carrie J. Gavora, "How Health Insurance Mandates Misdiagnose the Disease," Heritage Foundation *Backgrounder* No. 1108, April 10, 1997.

16. Melinda L. Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," Heritage Foundation *Backgrounder* No. 1211, August 14, 1998.

contribution formats.” Moreover, “[e]mployees... will find much to like once the concept takes hold.”¹⁷

PriceWaterhouseCoopers conducted a survey of “health care leaders” in the United States and found that 64 percent predicted a shift to defined contribution plans by 2010; 60 percent expected to see medical savings accounts in wide use by employers by that time.¹⁸

KPMG asked 103 senior executives and over 14,000 employees of *Fortune* 1,000 companies the following question:

What if you were able to select from any health plan being offered in your area, at the cost you choose, using both your employer contributions and the personal contributions you make, instead of having your employer select plan options for you? How interested would you be in this concept as a replacement for your health care selection options from your employer?¹⁹

The results are indicative of the growing interest in offering defined contributions to employees:

- 25 percent of respondents were “extremely interested”;
- 19 percent were “very interested”;
- 29 percent were “somewhat interested”;
- 23 percent were “not interested at all”; and
- 4 percent had “no opinion.”

Tax Credits. There is also considerable interest among policymakers in providing tax credits to individuals who do not participate in an employer’s plan toward the purchase of their health care coverage. This would enable them to

receive a tax benefit they do not currently receive but that workers who have employment-based coverage do receive. Recent research conducted by Mark Pauly and Bradley Herring of the University of Pennsylvania’s Wharton School of Business found that a tax credit equal to 50 percent of premiums would reduce the number of uninsured by half.²⁰

In June 1999, House Majority Leader Richard Armey (R–TX) and Representative Pete Stark (D–CA)—the self-described “congressional odd couple”—agreed in an opinion editorial published in *The Washington Post* that uninsurance is the “biggest health problem facing the country.”²¹ They also agreed on the root causes of uninsurance—a workforce that is “increasingly mobile and part time” and a perverse tax code that “discriminates against not only insurance purchased outside the workplace but also lower paid, part-time and small-business workers.”²² They promoted the idea of refundable tax credits as a “bipartisan remedy.”

Indeed, among Members of Congress, while there are some disagreements on the technicalities of tax credits, there is widespread bipartisan support for the concept itself. Over a dozen bills were introduced in the House and Senate during the 106th Congress to establish such tax credits. These bills had a combined total of 72 cosponsors from across the ideological spectrum. Moreover, both Governor George W. Bush and Vice President Al Gore included tax credits in their presidential campaign platforms.

Regardless of the technicalities, Congress should make the tax credits fully refundable, pre-payable, and available to all Americans. A non-refundable credit or deduction has zero value for the 45

17. Philip Lathrop, Gary Ahlquist, and David Knott, “Health Care’s New Electronic Marketplace,” Booz–Allen Hamilton, Second Quarter Report, 2000.

18. See <http://www.pwchealth.com/pr19991028.html>.

19. KPMG, LLP, “A New Direction for Employer-Based Health Benefits,” Report No. 99–12–05, 2000.

20. Mark Pauly, Ph.D., and Bradley Herring, “Expanding Coverage Via Tax Credits: Trade Offs and Outcomes,” *Health Affairs*, Vol. 20, No. 1 (January–February 2001), p. 14.

21. Dick Armey and Pete Stark, “Medical Coverage for All,” *The Washington Post*, June 18, 1999, p. A41.

22. *Ibid.*

percent of uninsured Americans who are not liable for the payment of federal income taxes.

Impact on the Current System. Some people claim that moving toward a system based on defined contributions and/or tax credits for the uninsured will jeopardize the current employer-based system. This need not be the case; but to the extent that it could, the impact of the change would be more than offset by empowering individuals and families to purchase their own health care. Today, 90 percent of privately insured Americans get their insurance from an employer,²³ and most are satisfied with that coverage. The role for employers in providing health care benefits is not threatened by the creation a new system for providing insurance coverage. Nothing would force employers to move to a defined contribution approach, except perhaps pressure from employees who are seeking more options.

Employers have an obvious interest in ensuring that their employees are healthy. They can continue to play this role by providing their employees with sufficient resources—money that receives the same tax treatment—so that employees can buy plans of their own choosing. This is the carrot approach. Employees who do not buy a plan would not get the money—a pretty strong incentive to join a plan. Employers could suggest plans and provide information, as many larger employers that offer multiple plans to their employees now do. Thus, the resources, information, and incentives would still be employer-provided. The only difference is that the employees would make their own choices from a universe of plans and would not be forced to rely on their employer's limited menu as they are today.

To further assuage the fears of those who want to preserve the employment-based system, limitations on tax credits could restrict their use to cases in which an employer makes no contribution to an employee plan—thereby erecting a “wall of separation.” (Congress could even decide that employers

who drop coverage should make that money available to employees as additional compensation.)

This tax credit also permits portability, so that individuals can maintain the same policy and coverage as they move between jobs or change their employment status. If Medicaid were properly reformed so that Medicaid dollars could be used for private plans of beneficiaries' own choosing, a family could also maintain the same private policy if they fell on hard times.

THE BENEFITS OF PERSONAL CHOICE IN HEALTH PLANS

The following are among the advantages for individuals and families who participate in a system that is based on defined contributions and/or tax credits:

- **Consumer choice of plans.** In 1998, only 17 percent of employers in the United States offered their employees a choice of plans.²⁴ The frustration of these workers provoked the debate during the last session of Congress on the right of patients to sue their health plans. If individuals were allowed to choose and switch plans, as they are in the Federal Employees Health Benefits Program (FEHBP), which covers federal workers and Members of Congress, the rates of dissatisfaction would diminish. Choice—something sorely lacking now—largely quells the desire to sue.
- **Consumer control over plans and accountability.** Facilitating individually owned policies would enable people to sign a contract directly with their health insurer. If the insurer violated the terms of the contract, the individual would be free to sue that insurance company for breach of contract without any uncertainty over employer liability. Real accountability would be established in the health insurance market.

23. William S. Custer *et al.*, “Why We Should Keep the Employment Based Health Insurance System,” *Health Affairs*, Vol. 18, No. 6 (November–December 1999), p. 116.

24. Steve Long and M. Susan Marquis, “How Widespread Is Managed Competition,” Center for Studying Health System Change *Data Bulletin* No. 12, Summer 1998, p. 1.

- **Insurers would be responsive to the wants and needs of families.** Under the current system, the purchasers and owners of health insurance are primarily employers, not the individuals and families covered by the plans. For this reason, insurance companies market their products (plans) to the employers, who are concerned primarily about cost rather than the design of the benefit package or the specific health needs of their employees and families. Although large *Fortune* 500 companies hire employee benefit managers who can take the time to study insurance policies and choose benefit packages that attract and retain employees, few if any small employers can do so. Small employers under the tight pressures of running a competitive business at a profit often have neither the time nor the expertise to study the needs of their diverse groups of workers to determine what plan could best accommodate all their needs. For many workers employed in smaller firms, the better option would be to purchase health insurance through an affinity group or organization that has a much larger pool of beneficiaries to spread the risk (see below). Examples of such groups are unions, religious groups, fraternal organizations, or college alumni associations.
- **Portability of health insurance.** The move to a defined contribution/tax credit approach would make portability of health insurance a reality, enabling people to maintain their coverage even if they changed jobs. The choice of doctor and insurance plan would no longer be controlled by the employer or by the worker's employment status. The Wharton School's Mark Pauly considers this to be among the "main advantages" of individual over group insurance.²⁵ Portability holds particular appeal for younger Americans who are more likely to change jobs and start new companies than are older workers. Portability also has tremendous appeal for people who have preexisting conditions. In today's system, a person's medical history can be a barrier to employment, especially in smaller firms, and to purchasing a new policy in the individual market. Defined contributions and tax credits could eliminate these barriers.
- **Consumer freedom to choose benefit plans that reflect their values.** A defined contribution/tax credit system would enable people to purchase policies that exclude benefits they find morally objectionable, such as abortion or contraceptive services. People of certain religious faiths who believe particular procedures like abortion are immoral should be free to purchase and participate in plans that coincide with their beliefs.
- **A "marriage bonus" in a world of defined contributions.** Actuarially speaking, the cost of insuring a married couple in most instances is less than the combined total cost of insuring the same two people individually. Although there is a considerable number of variables, a husband and wife who each receive a \$3,000 defined contribution from their employers, for example, would be able to buy a richer benefits package that covers both of them with the combined \$6,000 than they could by spending \$3,000 each on separate policies. Or they could purchase a less expensive plan and save the money left over in an interest-bearing medical savings account that they own and control, to use for unexpected or non-reimbursed costs. Today, many couples choose to be covered by just one partner's work-based health insurance plan. The other partner opts out of his or her employer's plan but does not reap a monetary gain from doing so. As is often the case, the company still pays to cover that worker. Under a defined contribution approach, this money would go to the worker to spend on health care.
- **Market expansion to affinity groups.** Defined contributions and tax credits would stimulate groups other than employment-based pools to sponsor their own plans for members. This would depend on Congress

25. Mark Pauly, Ph.D., *et al.*, "Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons," *Health Affairs*, Vol. 18, No. 6 (November–December 1999), pp. 28–44.

making the proper changes in the Employee Retirement Income Security Act of 1974 to create another category of health plans: “association health plans,” or AHPs. Unions (which in some instances have more than a million members nationwide), church groups, and alumni associations could offer plans to their members in all states. Most people are far more likely to be lifetime members of these organizations than they are to remain working for any one employer. Employers are simply not the only group capable of pooling random risks.

- **Consumer control over privacy of medical records.** A major concern of patients is what happens to information in their medical history. People want privacy and control of their medical records. They would have more say in what happens to their records if they were able to purchase their policies directly from insurers rather than obtain their coverage through their employer.²⁶ If an insurer violated the privacy provisions in the policy, the patient would have clear, unambiguous avenues to litigate that breach of confidence.
- **Lower costs per policy.** One of the inherent problems of the current state-based individual market is adverse selection. Those who buy also tend to be those who are most in need of health care services. Many healthy people just choose to take their chances, especially considering that they are often between jobs and uninsured for only a short time. This contributes to higher costs for all. If more healthy people joined the individual market as their primary, and permanent, means of obtaining insurance, costs would decrease for all.

Weak Objections. A common but patronizing objection is that people are not capable of making decisions about something as complex as health insurance. Yet people from all walks of life choose

banks to handle home mortgages, colleges to educate their children, and mutual funds for retirement savings, as well as fire, automobile, and homeowners insurance. Ordinary Americans are as capable of purchasing health insurance as federal employees are of picking their own health plans through the FEHBP. Moreover, their interest in picking a suitable plan for themselves and their families is far greater than that of any employer.²⁷

This obvious self-interest suggests that Americans would spend substantially more time and effort in selecting appropriate health coverage *and* do a better job of doing so relative to most employers. To assist them, companies are using Internet and intranet-based formats and creating tools to help employees choose the delivery systems and health plans that best meet their personal needs, in addition to providing the education and support services needed to make them good health care consumers.

Another oft-heard objection is that the cost of individually purchased plans is much greater than that of group plans. This is increasingly untrue. A study done by Professor Pauly found that the administrative cost differential between individual and group policies has been shrinking steadily since 1970. Pauly predicts further reductions in costs, especially if individuals achieve tax neutrality relative to employer group purchases of insurance. For example, mass-marketed non-group health insurance purchased over the Internet would likely experience changes that mirror what happened to automobile insurance in the 1970s when new laws permitted people to shop for the lowest rate over the phone.²⁸ In addition, tax credits and defined contributions would facilitate the purchase of health insurance by groups other than employers, so families would not necessarily be restricted to higher-cost, individually purchased policies.

26. Stuart M. Butler and Carrie J. Gavora, “How Tax Reforms Would Help Protect Patient Confidentiality,” Heritage Foundation *Background* No. 1242, January 19, 1999, at <http://www.heritage.org/library/background/bg1242.html>.

27. For a discussion of the sophistication of the American health care consumer, see Regina Herzlinger, *Market Driven Health Care* (Reading, Mass.: Addison–Wesley Publishing Co., 1997), pp. 249–253. See also Gina Kolata, “Web Research Transforms Visit to the Doctor,” *The New York Times*, March 6, 2000, p. A1.

28. Pauly *et al.*, “Individual Versus Job-Based Health Insurance,” pp. 33–39.

A search of policies available on the Internet confirms their affordability. While there are many variables, a typical policy for a single 30-year-old male can cost as little as \$600 per year, with few costing over \$2,000 annually. If he were given a \$1,000 tax credit to use to purchase a policy, his monthly out-of-pocket premiums would be between zero and \$83. (A state tax credit would bring any premium down even further.)²⁹ The employer's defined contribution would be more than \$1,000 (it would make no sense to offer less than the value of the \$1,000 tax credit), which means the premiums for this hypothetical individual would be even lower, if not nonexistent. Any "savings" could be kept in an MSA to help cover future medical expenses. As further evidence that mass-marketed, non-group Internet-based insurance is affordable and available, Vip Patel, the CEO of ehealthinsurance.com, has reported that the cost of a policy on his Web site averages half that of plans in the FEHBP.³⁰

TOP TEN WAYS TO INSURE ALL AMERICANS

To move seamlessly into the world of defined contributions and tax credits, current regulations must first be amended. Otherwise, providing resources alone would be insufficient, like giving someone a new car to drive where there are no paved roads. Congress and the Administration should seriously consider reforming the system in these 10 ways to improve access to health insurance and expand coverage for all Americans.

Step #1: Provide tax credits for the purchase of health insurance. First and foremost, Washington should make fully refundable, pre-payable tax credits available to all Americans. The tax credit must be fully refundable,

since 45 percent of the uninsured today are not liable for the payment of federal income taxes;³¹ a non-refundable credit would have zero value for nearly half of the uninsured population. The same is obviously true for a tax deduction. The tax credit must be pre-payable so that individuals and families can reap the benefit *at the time they purchase health insurance* rather than being forced to wait until the following April to receive a refund. The pre-payment mechanism need not be complicated and could simply involve transferring resources from the U.S. Treasury to an insurer, with the insurer changing its tax payments. Tax credit bills introduced during the 106th Congress by Representatives Armev and Stark included this feature.³²

Step #2: Clarify liability of employers that offer defined contributions. While defined contributions (the employer sends a pre-tax check to the health insurer of the employee's choice) can occur under current law,³³ the liability of employers that offer defined contributions is unclear. In making it possible for employees to contract directly with insurers, Congress should make plain in statute that an employer who makes a defined contribution to an employee's health plan is free from fiduciary responsibility. Representative Jim DeMint (R-SC) introduced H.R. 5568 to accomplish this goal during the 106th Congress and is working on a similar bill this session. Senator Michael Enzi (R-WY) suggested related language last year as a possible amendment to the Patients' Bill of Rights.

Step #3: Do for the public what Congress has done for itself. Congress should permit all employees in the private sector to make their

29. As found on <http://www.ehealthinsurance.com> (February 13, 2001).

30. Author conversation with Vip Patel, December 21, 2000.

31. Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs*, Vol. 19, No. 1 (January-February 2000), p. 79.

32. H.R. 2185 (Representative Stark) and H.R. 2362 (Representative Armev).

33. See Greg Scandlen, "Defined Contribution Health Insurance," *Policy Backgrounder* No. 154, National Center for Policy Analysis, October 26, 2000, p. 11.

contribution to an employer's health plan, or to add to an employer's defined contribution, using pre-tax dollars up to a maximum amount.³⁴ Congressional staffers began to enjoy this perquisite in the FEHBP in 2001. Although it is dependent on salary and plan selection, a typical staffer is likely to save several hundred dollars a year by contributing pre-tax dollars to his or her plan.³⁵ Surely, private-sector workers should enjoy the same opportunity and cost-saving benefit.

Step #4: End the caps on MSAs. Congress should lift the restrictions on MSAs so that individuals can participate regardless of their employment status or the size of their employer. Among the numerous benefits of MSAs is the ability for patients to go straight to any doctor or specialist they choose without first having to consult their primary care physician or an HMO bureaucrat.³⁶ Paying in cash and removing the third-party payer from routine doctor visits could reduce fees paid by patients by as much as 50 percent. That is the experience of a group of doctors in Seattle, Washington, who accept only cash from their patients and who have thus eliminated the bureaucratic headache of filing for payment from a third party.³⁷ Removing the third-party payer also would permit patients to take advantage of health care "buyers' clubs" like HealthAllies and Medadvantage, which offer

discounts on everything from prescription drugs to vision care and diabetes supplies.³⁸

The American Medical Association has said the limited MSA experiment authorized by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 should be

made permanent, and MSAs should be made available to everyone with full latitude for the market to determine specific MSA product features such as health plan deductible amounts, amounts of the contribution to MSA savings accounts, and maximum annual out-of-pocket spending amounts.³⁹

Moreover, support for MSAs in Congress has been bipartisan. Senate Minority Leader Tom Daschle (D-SD) and Senator John Breaux (D-LA) are among those who have commented favorably on MSAs in the past.⁴⁰

Step #5: Allow association health plans (AHPs).

Owners of small businesses should be able to band together across state lines to increase their purchasing power to buy less expensive insurance or to self-insure. Large multi-state corporations like General Motors already have this purchasing leverage. To allow such association health plans to form and flourish, however, ERISA will need to be amended. Small employers could then offer their employees a defined contribution or tax credit to use to

34. Sophisticated employers are aware that this can be done now by running employees' contributions through a Section 125 account. Unfortunately, not all employers are aware of this backdoor technique.

35. Walton Francis, *Checkbook's Guide to 2001 Health Insurance Plans for Federal Employees*, (Washington, D.C.: Center for the Study of Services, 2000).

36. For the best description of MSAs and their benefits to patients, doctors, and the entire medical system, see John C. Goodman and Gerald L. Musgrave, *Patient Power*, abridged version compiled by Michael Tanner (Washington, D.C.: Cato Institute, 1994).

37. See <http://www.simplecare.com>.

38. Mary Brophy Marcus, "A Buyers Club Can Help Beat Down Health Costs," *U.S. News & World Report*, November 13, 2000, p. 76.

39. American Medical Association, "Rethinking Health Insurance: The AMA's Proposal for Reforming the Private Health Insurance System," 1999.

40. "Dear Colleague" letter on the Medical Cost Containment Act of 1992 (S. 2873), signed by Senators Daschle and Breaux as well as Richard Lugar (R-IN), David Boren (D-OK), Daniel Coats (R-IN), and Sam Nunn (D-GA).

purchase AHP coverage. Large organizations such as the National Federation of Independent Business, National Restaurant Association, Associated Builders and Contractors, and other employer-member groups are obvious candidates for such plans.

Representatives James Talent (R–MO) and Calvin Dooley (D–CA) introduced H.R. 1496 during the 106th Congress to permit such AHPs. The legislation garnered a broad base of 47 bipartisan cosponsors and ultimately was rolled into H.R. 2990, which was passed by the House in October 1999. Allowing AHPs also was the goal of legislation introduced by Representatives Charles Norwood (R–GA) and John Shadegg (R–AZ) during the 106th Congress (H.R. 1136 and H.R. 1687, respectively).

Step #6: Permit individual membership associations (IMAs). Congress should amend ERISA to permit IMAs to sell health insurance, a feature in Representative Shadegg’s bill. Such affinity groups as a college alumni association, the Kiwanis International, the American Bar Association, or the Southern Baptist Convention, which have members in many different states, should be able to offer their members health coverage. Like AHPs, IMAs would enable people to band together in large pools across state lines. A particular advantage of IMAs is that the individuals in them often remain lifetime members. Obtaining policies through an IMA would provide them with continuity of coverage no matter how many times they changed jobs in addition to passing on all of the benefits of continuous coverage, such as familiarity with provider networks. Both tax credits and defined contributions could be used toward the purchase of an IMA plan.

Step #7: Allow consumers to choose between plans covered by federal or state regulations. Congress should amend ERISA so that a

plan paid for by an employer’s defined contribution is considered an individual plan and therefore subject to state insurance law. Under current law, any employer-provided health insurance is automatically considered a group plan, bringing with it a specific set of ERISA regulations. This forces individuals into only one regulatory environment instead of providing them with a choice. Instead of remaining the last resort for people who cannot get coverage elsewhere, state insurance pools would become considerably more stable, with a large influx of random risks. In Professor Pauly’s words, “If non-group insurance became more prevalent, the market for such insurance would be flooded with reasonably good risks.”⁴¹

Step #8: Encourage responsible buying of insurance. One way to do this is to eliminate the “guaranteed issue” provision in HIPAA, which mandates that insurance companies and HMOs selling in the small group market (businesses with two to 50 employees) *must* accept any employer and its collection of employees that applies for coverage, regardless of employees’ health or the employer’s claims history.⁴² This “guaranteed issue” provision allows purchasers of insurance to obtain coverage only when they need it, which is similar to allowing someone to buy homeowner’s insurance after the house burns down. This provision violates the most fundamental principle of insurance and increases the rates everyone else must pay. At the very least, Congress should include a 90-day or 180-day waiting period before coverage can start. This would give employers the incentive to insure their workers more responsibly and individuals an equally powerful incentive to obtain coverage before needing it. The highest-cost and most vulnerable population would be eligible for high-risk pools (see Step #10).

41. Pauly *et al.*, “Individual Versus Job-Based Health Insurance,” p. 38.

42. Beth C. Fuchs *et al.*, “The Health Insurance Portability and Accountability Act of 1996: Guidance on Frequently Asked Questions,” Congressional Research Service, June 4, 1998, p. 10.

Step #9: Formalize federal regulation with a new federal charter as an alternative to state regulation. Today's health insurance market is a complex maze of federal and state regulation, with often confusing overlap and duplication. The regulatory system drives up health care costs for everyone involved. Congress should examine the feasibility of creating a new federal charter for health insurers and consumers to eliminate confusion and duplication.

To do this, Congress could task the National Association of Insurance Commissioners (NAIC) with the job of setting solvency requirements and overseeing underwriting standards. It would be important, however, for NAIC's role to be statutorily limited to these areas so that it does not encroach on the ability of insurers to create benefits packages and consumers to buy plans of their choice. Any insurer and individual or group of people that wished to purchase health insurance could operate in this federally regulated charter. Health care consumers would then have the option of purchasing insurance in either their state-regulated market or the new federally regulated market, much as consumers can now choose between state and federally regulated banks.

It would also be critically important for Congress and federal regulators to be cognizant of the lessons learned from the experience of those states that have placed excessive mandates and regulations on their health insurers and negatively affected the market as a result, in order to avoid repeating their mistakes. Included in the federal charter should be a national high-risk pool to provide coverage for people in the greatest need.

Step #10: Promote a national high-risk pool.

Policymakers should promote a national high-risk pool as part of the federal charter. The inclination of market-based health insurance is toward risk segmentation. This happens when the best risks get cheaper premiums while the bad risks pay higher rates. To some extent, risk segmentation is a good and fair thing—people who lead healthy lives and get regular check-ups should pay lower premium rates. Younger people who typically use fewer medical services should pay less than older people who use more.⁴³ The problem arises when certain individuals, because of their high fixed costs or significant risk factors, are denied coverage altogether. These so-called uninsurables represent as little as 1 percent of the population, but their needs are the greatest.⁴⁴

To help this specific population, 28 states have established high-risk pools. The purpose of a high-risk pool is to allow individuals who would otherwise be uninsurable in the private market because of preexisting conditions to buy coverage at a rate that does not reflect their true costs. The best way to fund the pool is to assess private insurers operating in that market based on their share of the market. This is the most reasonable way to achieve the shared societal goal of providing for those most in need without overregulating the health insurance industry. But it would be of the utmost importance that individuals not be allowed to buy in when they become sick, which is like allowing people to buy auto insurance after their cars are stolen and violates the underlying principle of insurance. To encourage responsibility, a waiting period of six months or a year should be required before a person is eligible to participate in the high-risk pool. State-run risk pools have been in

43. The alternative is a system that tends toward community rating of premiums, whereby the young and healthy are charged premiums similar to those charged to older people. The predictable result is that younger people who do not see a good value for their money drop out of the pool and a so-called death spiral ensues. It is worth noting that the average 55-year-old worker earns nearly twice as much as the average 25-year-old.

44. Conrad Meier, "Extending Affordable Health Insurance to the Uninsurable," *Heartland Policy Study* No. 91, Heartland Institute, August 27, 1999.

existence since 1976; 250,000 otherwise uninsurable people have had access to comprehensive health insurance because of high-risk pools.⁴⁵

CONCLUSION

Congress and the Bush Administration can begin to take immediate steps to reverse the rising number of Americans who go without health insurance at some point during the year. They should look boldly beyond the increasingly outdated model of employment-based coverage and focus on new strategies that will better serve Americans in the 21st century economy.

Providing resources directly to individuals and families through refundable tax credits and defined contributions while reducing regulatory barriers for alternative pooling mechanisms and health insurers would unleash market forces that have been hamstrung by a complex and confusing set of contradictory federal and state policies. Such changes would usher in the kind of competition that the current system lacks and promote freedom, affordability, and choice in the health care sector. It is time to free the health insurance market to function as vibrantly as virtually every other segment of the economy in meeting the needs of all Americans.

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45. Insurancevalues.com, “Risk Pools: Where to Turn If You’re Medically Uninsurable,” at <http://www.healthinsurance.org/riskpoolinfo.html>.