Miller Proposal

Key Elements

Tom Miller has provided a detailed blueprint for a reformed health care system that would try to promote efficiency and economy by re-designing incentives, especially by assigning more responsibility for health spending decisions to individual consumers and less to third-party payers. The plan would put more emphasis on achieving access to health services than on expanding insurance coverage. It includes the following elements:

TAX CREDITS AVAILABLE to everyone that could be used to purchase high-deductible insurance coverage.

GREATER EMPHASIS ON EXPANDING the safety net system as an alternative to covering all of the uninsured.

IMPROVED FUNDING FOR and accessibility to high-risk pools.

GREATER FLEXIBILITY in health insurance regulation, provided by promoting inter-state regulatory competition to attract insurers.

CHANGES IN THE INCENTIVES that now encourage choice of employer-based coverage over individual coverage.

TAX INCENTIVES TO ENCOURAGE voluntary contributions to agencies serving the uninsured.

About the Author

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Improving Access to Health Care without Comprehensive Health Insurance Coverage: Incentives, Competition, Choice, and Priorities

by Tom Miller

Vision

A reformed health care system would restore control of health spending decisions to the individual consumer and reduce the role of third-party payment for ordinary health care expenses. Third parties would compete in private markets to be agents of consumers, rather than maneuvering through the political system to acquire their own shares of health care spending. Health care would be decentralized, depoliticized, diverse, and dynamic. When health care is delivered in this manner, it will be less expensive, more accessible, provide greater value, and better match the needs and preferences of individual consumers.

Market-based reform begins with more neutral tax treatment of health insurance purchasing options, emphasis on protection against major risks, and deregulation of health care suppliers. Instead of more regulation and litigation, such reform restores the vital role of voluntary contracts and market prices. It also:

- reintegrates public program beneficiaries into the choices offered by the private, competitive health care system;
- accelerates the transition from the current set of defined benefit group health plans controlled by employers and government agencies to defined contribution health financing that responds to individual consumers' needs and preferences;
- harnesses the potential of greater convergence between health care financing and financial services; and
- facilitates the consensual flow of health information.

Overview of Major Objectives

Improving health outcomes and health status for lower-income individuals should be the primary goal of health care system reform. Increasing health insurance coverage levels per se remains at best an imprecise tool of limited effectiveness in achieving that objective. It may well be more efficient, on balance, to selectively target expansion of safety net care than to subsidize expansion of conventional health insurance coverage to reduce the number of uninsured Americans.

To achieve better health outcomes, we need to provide individual health care consumers with stronger incentives to be cost-conscious in using scarce medical resources. Making the market-based cost of care more transparent to all parties involved in health spending decisions will encourage its more efficient consumption and delivery. Reducing the long-term rate of growth in the cost of health care remains more important than (and, beyond a certain point, operates at cross-purposes to) expanding the scope and scale of subsidized health insurance coverage. Health insurance subsidies increase not just the demand for health care but also the total *cost* of health care, creating net welfare losses estimated at 20 percent to 30 percent of total insurance spending.[1] In the opposite direction, access to "free" care dampens the demand for private health insur-

[1] Martin Feldstein. *Hospital Costs and Health Insurance.* Cambridge, MA, and London: Harvard University Press, 1981, pp. 99, 201–03, 239–44; Martin Feldstein. "The Welfare Loss of Excess Health Insurance." *Journal of Political Economy 81* (2) (1973): 251–80. See also Edgar A. Peden and Mark S. Freeland. "A Historical Analysis of Medical Spending Growth, 1960–1993," *Health Affairs 14* (2) (1995): 236–47 (finding that about half the growth in real per capita medical spending from 1960 to 1993, and two-thirds of its growth from 1983 to 1993, resulted from either the level or growth of insurance coverage).

ance.[2] In striking the necessary balance, the net effects of comprehensive third-party insurance (raising costs and thereby limiting access to health care) substantially outweigh any disincentives to obtain insurance protection that may be caused by direct provision of charity care. When rising health care expenditures outpace wage increases, their strongest effect is to reduce health insurance coverage for low-income workers.[3] Hence, at the margin, increasing incentives to purchase less-comprehensive health insurance and filling in urgent gaps in direct delivery of health care through safety net mechanisms may produce more affordable and accessible health care.

Target Population

To expand access to health care, we should focus primarily on the working uninsured (and their dependents): those workers who currently decline the employer-sponsored insurance coverage offered to them, workers in smaller firms that do not provide insurance coverage, workers prone to frequent job turnover and short-term employment, and self-employed individuals. Other targets would include Medicaid-eligible individuals who currently decline such coverage, State Children's Health Insurance Program (S-CHIP)-eligible families that currently decline such coverage, and workers dissatisfied with the terms of their existing employer-sponsored coverage. A market-based reform approach for *all consumers* would not only reduce the future cost of health care (that is, at least lower its rate of growth), but also improve its quality through enhanced accountability to purchasers in a more competitive, value-conscious environment.

Expanding Access to Care by Empowering Workers with Better Incentives and New Options

This proposal would rely on new incentives, rather than explicit mandates, to expand availability of market-enhancing health care options. Rather than destabilize current arrangements, it would structure a menu of alternatives that trade off somewhat lower subsidies in return for greater choice and flexibility, more economizing opportunities, and long-term sustainability. The tools include a new tax credit option available to purchasers of non-employer-group, high-deductible insurance; medical savings accounts; defined contribution health plans; voluntary purchasing pools; a competitive federalism approach to insurance regulation; and a strengthened safety net system that includes federal subsidies for high-risk pools and tax incentives for charitable contributions to non-profit providers of safety net health care.

Tax Policy—Moving toward Parity

The primary vehicle for accomplishing various market-strengthening reforms that lower future health care costs and expand access to health care would be a new federal tax credit option. The tax credit would amount to 30 percent of the cost of qualified insurance coverage (see "Subsidies," below, for an explanation of why that specific percentage was chosen). Essentially, individuals could subtract this portion of their insurance costs directly from their federal income tax liability.[4]

The tax credit is an *option;* it would not eliminate the current tax exclusion that is available for workers insured by employer-sponsored insurance (ESI) plans. (A similar federal income tax deduction also is available on a partial basis—70 percent of the

[2] Bradley J. Herring. "Does Access to Charity Care for the Uninsured Crowd Out Private Health Insurance Coverage?" Yale University Institution for Social and Policy Studies working paper. September 7, 2001; Bradley J. Herring. "Access to Free Care for the Uninsured and Its Effect on Private Health Insurance Coverage," Dissertation on Health Care Systems, University of Pennsylvania, 2000.

[3] Richard Kronick and Todd Gilmer. "Explaining the Decline in Health Insurance Coverage, 1979–1995." *Health Affairs 18* (2) (1999): 30–47 (observing that "persons with few assets to protect will get no greater benefits from insurance when health care prices are higher than when they were lower... .").

[4] It would be approximately comparable to "excluding" from one's income that is subject to federal income taxes and federal payroll taxes an amount equal to what one spends on qualified private insurance coverage in a given year—except that rather than applying one's marginal federal tax rates to the excluded amount to determine one's net saving on taxes, a taxpayer would reduce his net federal income tax liabilities by 30 percent of that amount.

cost of qualified health insurance—for the self-employed, and it will become 100 percent deductible from federal taxable income in 2003.) Instead, it would provide a competitive alternative to the tax exclusion for those workers to opt for in place of the tax exclusion. It would encourage a more gradual transition toward other forms of private insurance coverage. Workers who choose to enroll in an ESI group plan would continue to use the current tax exclusion. Employees who choose to decline ESI coverage and not take advantage of the current tax exclusion could use the tax credit option instead to purchase other forms of health insurance coverage.

The tax credit also would be made available to other individuals and families that currently do not qualify for the tax exclusion because they lack access to employer-sponsored insurance coverage. The tax credit option would move policy closer to tax treatment parity (horizontal equity) for those workers and other federal taxpayers with non-ESI coverage.

Employers that continue to provide ESI coverage would be required to report the value of the employer-financed share of that coverage to individual employees on their regular periodic pay statements and annual W-2 forms. In the event that employers were not allowed to charge different employees different prices for their share of group insurance coverage (that is, no repeal of the non-discrimination rule for health status under the Health Insurance Portability and Accountability Act), employers would report the periodic equivalent of the per-employee Consolidated Omnibus Budget Reconciliation Act (COBRA) premium, minus the administrative charge allowed for COBRA. Disclosure of this information would assist individuals in choosing between the tax benefits of the current system and those provided by a new tax credit option.

The new 30 percent tax credits would be assignable (to insurers providing coverage). They also would be advanceable, in the sense that an eligible taxpayer purchasing health insurance could receive a 30 percent tax credit "discount" at the time of payment. In the event that an eligible individual wished to pre-pay his or her health insurance premiums for periods beyond a month and up to a full year, the individual could receive the full 30 percent credit up front and apply it to those insurance premiums. However, the maximum tax credit available for any eligible individual would be no greater than that individual's total federal income tax and Federal Insurance Contributions Act (FICA) tax liability (including both the employer and employee shares of the payroll tax) for the previous calendar year. In other words, only taxpayers would receive tax credit "relief" for health insurance costs.

Because the maximum amount of an advanceable tax credit is determined by an individual's tax liability for the previous year, concerns about year-end reconcilability (to recapture excess tax credit payments relative to annual taxable income) should be reduced. Nevertheless, it may be necessary to ensure more predictable tax relief for individuals with fluctuating amounts of annual taxable income. If these latter individuals choose to use the tax credit option, then they also would be allowed to use three-year income averaging for federal income tax returns (subject to maximum annual taxable income eligibility caps, to limit excessive tax arbitrage). Such income averaging also would help individuals adjust the maximum amount of their tax credit for a given year, to deal with unusually higher health insurance expenses.

Even if an employer were no longer "paying" directly for an employee's insurance coverage under an employer-sponsored group plan, the employer still could facilitate delivery of health tax credit assistance through several mechanisms.

An employer could choose to include in an employee's gross wages an amount equivalent to what the employee otherwise would have received as the non-taxable employer's contribution to the employee's applicable share of any group coverage offered under the employer's health benefits plan.

An employer could "list bill" and allow employees using the tax credit option to pay their individual insurance premiums through payroll deduction (that is, an insurer bills the employer for a list of designated employees who have opted for non-employer-sponsored coverage). In the latter case, the workers would bear the entire premium, but apply their tax credit to reduce the net payment due.

An employee could request that the employer adjust income tax withholding, to reflect the likely value of the health tax credit.

An employer and his or her employee simply could renegotiate a new salary level (reflecting non-participation in the employer-sponsored group plan and the accompanying non-use of the tax exclusion) and let the employee pay insurance premiums and use the tax credit on his own.

The net effect of these reforms would be to encourage workers and their families either to move from employer-based coverage to individually purchased insurance, or to ensure that the ESI coverage they select represents the best competitive value they can find.

To be eligible for this tax credit option, employees and other individual health care consumers must purchase an insurance package that covers a minimum set of health services and includes a minimum, but significant, front-end deductible. The minimum covered services would be defined as those health services covered by the local market area's least expensive plan for federal workers under the Federal Employees Health Benefits Program (FEHBP) or the particular state government's least expensive health plan offered to its employees. Insurers could offer a wider variety of benefits at higher prices, but all plans eligible for the tax credit must be catastrophic plans, that is, they must include a minimum deductible level and a maximum out-of-pocket (stop-loss) level. A likely figure for minimum deductibles for single coverage might be the lower of $2,000 or 5 percent of taxable income. The likely maximum stop-loss level (the maximum out-of-pocket cost) would be the lower of $5,000 or 10 percent of taxable income.[5]

Of course, eligible plans could set even higher deductible levels, or lower stop-loss levels, as long as the two paths did not cross (that is, the stop-loss level could not be lower than the deductible).

Funds available through the tax credit could not be used to purchase more comprehensive insurance coverage with less cost sharing (that is, with deductibles below minimum levels). Insurers selling more comprehensive coverage to individuals using tax credits first must offer them a separately priced policy at the same time with deductible and stop-loss levels that comply with catastrophic coverage cost-sharing limits.

However, individuals using health tax credits for insurance coverage also could make other tax-advantaged contributions to individual health savings accounts, with a choice of two types of tax treatment.

1. *Pre-tax, regular individual retirement account (IRA)-style tax treatment.* Contributions would be deductible/excludable against federal income and payroll taxes, with tax-free inside buildup on investment income, until they are withdrawn. If withdrawn for Internal Revenue Code (IRC)-eligible health spending purposes before the recipient is age 65, they would be subject to federal income taxes and deferred collection of federal payroll taxes only to the extent of the original amounts contributed (that is, no tax recapture of the inside buildup of investment income). Withdrawals of funds before age 65 for other purposes would be fully subject to federal taxes. At age 59½ and later, accumulated funds could be rolled over tax-free into individual IRAs or into contributions to Medicare medical savings accounts (MSAs).

2. *Post-tax, Roth IRA-style tax treatment.* Post-tax contributions would receive inside buildup on investment income, with no further taxes on any withdrawals for IRC-eligible health spending purposes. No additional federal taxes would be imposed on the applicable investment income share of any non-health withdrawals, as long as an individual, after any such withdrawals, still retained funds in the health savings account that equaled or exceeded 75 percent of the applicable annual deductible in any accompanying qualified insurance policy.

Deposits to an individual health savings account for any single year could not exceed the amount of

[5] Minimum deductibles and maximum stop-loss levels, of course, would be higher for family coverage. Adjusted gross income for the previous federal income tax filing year would provide the most likely measure of one's "taxable income." There is a trade-off between administrative simplicity and sensitivity to ability to pay in setting minimum deductible levels and maximum out-of-pocket cost limits. Pegging such levels to vary with adjusted gross income would require private insurers either to offer a wider range of deductible and stop-loss levels or to become more engaged in monitoring income levels of their customers. On the other hand, simply setting a single, fixed numerical level for minimum deductibles or maximum stop-loss limits would undershoot or overshoot the financial ability of many customers to handle them.

the annual deductible in one's accompanying qualified insurance policy.

Using the Tax Credit Option to Leverage Other Reforms

Health insurance coverage purchased with funds from the federal tax credit would have to meet several additional criteria. Such policies would have to provide a separately priced guaranteed renewal option (but they would be otherwise exempt from HIPAA's guaranteed renewal requirements for other group health care plans). They would be exempt from individual state benefit mandates.[6] When approved, either by the insurance department in a state in which the issuing insurer is both domiciled and receives at least 25 percent of its total health insurance premium revenue, or by a "default" federal health benefits regulator at the Department of Labor, any such insurance policy would have to be given reciprocal approval in any state in which an individual purchaser chooses to purchase that policy. The default federal regulator would charter nationwide high-deductible catastrophic care policies in the event that individual state regulators failed to approve them.

Health insurance coverage purchased with federal tax credits could also be provided by voluntary purchasing pools that meet certain minimum criteria that include capital and solvency requirements. Such pools would have to provide annual open seasons and be open to all willing purchasers who use the health tax credit option.

Purchasing pools have the potential to provide an efficient mechanism for workers to gain a wider choice of health plans than many employers (particularly smaller ones) can offer on their own. Indeed, they may provide effective alternatives to poorly performing employer-selected health plans. For that reason, pool participation should not be limited just to business firm buyers making collective decisions for all their employees. Membership in "voluntary" purchasing pools should reflect the preferences of individual workers and other health care consumers, not just the interests and convenience of employers.

The role of purchasing pools would be to provide a single, stable source of ongoing coverage. They would ease the burden of choosing and buying coverage, particularly for people seeking insurance without the assistance of an employer. Pool administrators would help design benefits packages offered to individual pool participants. They would negotiate contracts and premiums with the health plans choosing to sell to pool members. In short, pool administrators would and should be effective purchasers and advocates on behalf of their members.

But the record for most such purchasing pools in the recent past has been disappointing. Early experiments with association health plans, health marts, and other health insurance purchasing cooperatives (HIPCs) have failed to attract a critical mass of customers needed for bargaining leverage and economies of scale. They also have been plagued by operating rules (community rating, state-level limits on risk classification and rate differentials, curbs on multi-year lock-in commitments) that increase adverse selection. The most likely pool customers have been those most likely to have greater long-term health care claims costs. Low-risk individuals and employer groups are less likely to join, and they are most likely to leave early, once they learn of their relative risk status within the pool in any event.[7]

Hence, any pools accepting funds from tax credit beneficiaries would be allowed to operate under the following ground rules:

• Tax credit-eligible purchasing pools would be allowed to require those buying insurance to commit to multi-year contracts—either to a particular health plan or to the pool in general.

• To deal with adverse selection concerns, yet still provide long-term protection against health risk redefinition, eligible purchasing pools could indi-

[6] State-mandated laws that require insurance coverage of particular types of health providers or services also increase the cost of health insurance and reduce covered workers' wages. Gail A. Jensen and Michael A. Morrisey. "Employer-Sponsored Health Insurance and Mandated Benefit Laws." *Milbank Quarterly 77* (4) (1999): 425–59. As many as 20 percent to 25 percent of the uninsured lack health insurance due to state mandates. Frank A. Sloan and Christopher J. Conover. "Effects of State Reforms on Health Insurance Coverage of Adults." *Inquiry* 35 (1998): 280–93.

[7] Tom Miller. "A Regulatory Bypass Operation." *Cato Journal 22* (1) (2002): 85–102.

vidually rate new entrants for their first two years in the pool, based on pre-announced underwriting rules, to the extent that those entrants present significantly heterogeneous risk profiles. People who remain with the same health plan for more than two years thereafter would be subject only to annual premium increases that reflect overall plan experience within the pool (in effect, a modified form of guaranteed renewability protection after year two).[8]

• To discourage low-risk customers from being enticed away from their pools by other insurers offering lower premiums to them, pools could attach "early exit" disincentives or other types of binding mutual constraints that encourage customers to remain in the pool on a long-term basis. For example, pool administrators and participating plans could structure annual premiums in two tiers—leaving the retained, second-tier portion of an individual's premium payment at risk of forfeiture upon early exit from the pool. (Or, more positively, the second-tier funds would be held in reserve as a potential "bonus payment" or rebate for continuous participation in the pool for a pre-specified duration.) Second-tier payments also could be subject to transfer or "settling up" in the event individual pool participants switch health plans during annual open seasons. Individuals demonstrating superior health risk profiles would leave some money behind in their old plans when they switch, whereas higher-risk individuals would transfer some of those funds over to their "new" plan. Pool administrators could negotiate with participating plans to determine the parameters of such "time-consistent" health insurance arrangements and contingent "severance payments," as first proposed by Cochrane.[9]

The above incentives and disincentives could be needed to discourage self-identified low-risk individual participants from selectively leaving the purchasing pool early, thereby raising average pool costs. However, adverse selection concerns might be dampened to some degree by the lack of an upper dollar limit on tax credit assistance to high-risk, high-cost individuals. As their premiums rise, so, too, would their 30 percent tax credit discount on insurance costs.

Effective voluntary purchasing pools would need several other new tools. They should be allowed to offer benefit packages that are exempt from state benefit mandates. Any state fictitious group laws[10] or state rating laws that would interfere with operations of eligible purchasing pools would be subject to federal pre-emption. Health plans competing within such purchasing pools would be allowed to set their own overall premiums based on their claims experience with the pool.

Pool administrators could enhance their effectiveness by using authority to contract selectively with particular health plans and by organizing employer-based enrollment and payroll deduction services for pool participants. Ensuring that purchasing pools serving federal tax credit recipients receive "charitable purpose" federal tax status would enhance their ability to attract start-up funding from private foundations.

Unless and until voluntary purchasing pools reach sufficient size to achieve competitive clout, they might need to balance risk redefinition protection objectives against desires for a broader menu of health plan choices for pool participants. Benefits standardization and limits on the numbers of eligible plan sponsors reduce the magnitude of adverse selection and the need for risk adjustment, but at the cost of consumer choice and market competition. The only honest answer will come from trial and error entrepreneurial experimentation in a less-

[8] See, for example, Bryan Dowd and Roger Feldman. "Insurer Competition and Protection from Risk Redefinition in the Individual and Small Group Health Insurance Market." *Inquiry 29* (1992): 148–57.

[9] John H. Cochrane. "Time Consistent Health Insurance," *Journal of Political Economy 103* (3) (1995): 445–73. See also Mark Pauly, Andreas Nickel, and Howard Kunreuther. " Guaranteed Renewability with Group Insurance." *Journal of Risk and Uncertainty 16* (1998): 211–21. Other exit disincentives might include greater use of front-loaded contracts to enhance the sustainability of long-term protections and minimize adverse selection incentives. Igal Hendel and A. Lizzeri. "The Role of Commitment in Dynamic Contracts: Evidence from Life Insurance." Cambridge, MA: National Bureau of Economic Research Working Paper No. 7470, January 2000.

[10] Such laws generally aim at preventing any fictitious grouping of a firm, corporation, or association of individuals from combining risks to obtain a preferred insurance rate or premium. For example, a law may require that private associations that purchase health insurance for their members must have a bona fide professional or trade purpose.

regulated marketplace. In any case, the combination of expanded purchasing options and long-term risk protection that finds the most buyers would begin to narrow the significant administrative cost differential between larger-employer group plans and other insurance purchasing choices.[11]

Tax-Advantaged Savings Vehicles for Individualized Health Care

Other tax policy reforms (apart from the optional federal tax credit) include universal availability of permanently authorized tax-advantaged MSAs and multi-year rollovers of section 125 flexible spending account balances ("use it or keep it").

The potential of current-law Archer MSAs has been hampered by eligibility limits, a narrow range of permissible insurance deductible levels, and a low numerical cap on individuals eligible for what has been a demonstration project of limited duration under HIPAA. Instead, MSAs should be authorized permanently (rather than temporarily authorized through December 31, 2003). The tax benefits for such accounts would be available to anyone covered by qualified high-deductible insurance—including workers insured under group health plans sponsored by employers with more than 50 employees and any individuals purchasing qualified high-deductible insurance on their own or as part of a non-employer group arrangement. Current law would be revised further to remove enrollment caps and maximum deductible limits, allow MSA account holders to fully fund their MSAs each year (up to 100 percent of the accompanying catastrophic insurance policy deductible), allow employers and employees to combine their contributions to MSAs at any time within a given year, and pre-empt first-dollar state-mandated benefits that would otherwise apply to HIPAA-qualified MSA plans.[12]

Because MSA plans already are linked to high-deductible insurance that covers health claims that are more catastrophic in nature, they can make the cost of insurance coverage more affordable for most Americans. Less-comprehensive coverage means lower insurance premiums for a larger fraction of people with low incomes—particularly those low-risk people who may want less than full coverage and, therefore, may decide not to purchase higher-priced, standardized insurance policies.[13]

Current tax treatment of Internal Revenue Code section 125 "flexible spending" health accounts (FSAs) would be revised to allow year-end, tax-free rollovers of accumulated balances, up to the amount of the annual deductible in the accompanying employer group plan for the applicable year. By ending the current tax treatment of "use it or lose it" for year-end balances, FSA funds could be saved for higher-value use in succeeding years.[14] However, withdrawals for non-health-spending purposes would be subject to income taxes.

Facilitating Defined Contribution Employer Health Benefits

A growing number of employers are beginning to offer defined contribution (DC)-style health benefits plans, in which the employer purchases less-comprehensive, high-deductible group insurance coverage for workers covered by the plan and then makes cash contributions to those workers' individual health accounts. DC plans help employers cope with rising health insurance costs by capping their total health benefits contributions, increasing employee cost sharing, and empowering workers to handle more routine health care decisions.

Fewer than half (43 percent) of ESI-covered

[11] For a more comprehensive analysis of risk pooling, administrative costs, and public policy options in various segments of the health insurance marketplace, see Mark Pauly and Brad Herring. *Pooling Health Insurance Risks.* Washington: AEI Press, 1999, pp. 81–89.

[12] See Victoria C. Bunce. "Medical Savings Accounts: Progress and Problems under HIPAA." Washington: Cato Institute Policy Analysis No. 411, August 8, 2001.

[13] Ibid. See also Katherine Swartz. "Rising Health Care Costs and Numbers of People without Health Insurance." Prepared for the Council on the Economic Impact of Health System Change conference, "Renewed Health Care Spending Growth: Implications and Policy Options," Washington, January 11, 2001. Swartz notes that the majority of standardized policies currently available are "generous and expensive—making them unaffordable to low-income people." Catastrophic insurance for less-predictable health care expenses would force consumers to bear the full marginal costs of health care up to the point where their use of health care exceeds the deductible. (Swartz recommends that health insurance coverage should define "catastrophe" relative to an insured customer's income.)

[14] The Bush administration has proposed a limited tax-free rollover of FSA balances at the end of a calendar year, but only up to a maximum amount of $500.

workers are satisfied with the overall performance of their current health plan. Fewer than half (48 percent) trust their employer to design a health plan that will provide the coverage they need, and approximately the same number of employees (47 percent) think better health plans are available for the same cost. Almost four out of 10 employees (39 percent) want their employer to contribute a fixed-dollar amount toward the premium for any health plan—even if it means the employees have to find their own health plan.[15]

DC plans allow employers to purchase less expensive, less comprehensive group health insurance coverage for their workers, yet still fund individual health spending accounts to handle the workers' more routine health care needs—so-called "two-tiered" health benefits plans. A "purer" form of defined contribution plan would even allow employees to select their own individual insurance coverage, with the assistance of their employer's original contribution. Whether individual employees pay just the extra cost of additional out-of-pocket health spending or the extra cost of more generous insurance coverage as well, DC plans provide incentives to compare the value of the health care they receive to other goods and services they might want.

DC plans might provide a halfway house in the transition from comprehensive ESI to high-deductible MSA plans. Value-conscious employers and employees could insist that insurers "spin off" (not insure) items about which little uncertainty exists or for which the typical treatment cost is relatively low compared to the paperwork required to process the claim.[16] Possible examples include orthodontics, regular checkups (medical, dental), vaccinations, maternity care, eyeglasses, etc. Whereas MSA plans rely on much higher deductible levels for accompanying catastrophic insurance policies and treat all insured services equally, two-tiered DC plans could provide certain "preventive care" health services with first-dollar coverage, while others might not be covered at all.

To the extent that either tax-preferred FSA accounts (with year-end rollovers) or individual health savings accounts in two-tiered DC plans would reduce the reliance on more expensive comprehensive insurance coverage, they would benefit the less healthy, since these individuals tend to have higher out-of-pocket costs than those who are healthy.

Despite the potential benefits of two-tiered DC plans, as well as the recent tax guidance issued by the Internal Revenue Service clarifying how accumulated balances in an individual employee's health reimbursement accounts may be treated when rolled over at the end of a year,[17] several regulatory barriers to the future growth of DC plans still need to be removed.

First, "pure" DC plans for fully insured employer groups, in which an employer distributes defined health benefits contributions to each eligible employee and allows them to purchase their own individual or non-employer-group insurance coverage, run the risk of being regulated inconsistently. They might be treated both as employee welfare benefit "group" plans and as "individual" health plans under state law.[18]

To clarify the regulatory treatment of this kind of DC plan, any plan or fund under which medical care is offered to employees by an employer solely through provision of a monetary payment or contribution to a participant or beneficiary and that is used exclusively to purchase individual health insurance coverage should not be considered an "employee welfare benefit plan" for regulatory purposes under the Employee Retirement Income Security

[15] Watson Wyatt Worldwide. *Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management.* Washington: 2001.

[16] See James H. Cardon and Mark H. Showalter. "An Examination of Flexible Spending Accounts." *Journal of Health Economics* (November 2001): 953.

[17] Employer contributions to such accounts would not be treated as taxable income, as long as they were spent for IRS-eligible health items or "saved" in the account and rolled over beyond the end of a calendar year for future use in paying health care expenses. The accumulated funds would be subject to income taxes and deferred payroll taxes in the event they are withdrawn for other reasons, with the exception of rollovers into other tax-advantaged retirement accounts.

[18] See Department of Health and Human Services, Health Care Financing Administration. "Insurance Standards Bulletin Series—INFORMATION." Program Memorandum Transmittal No. 00-06, November 2000 (conveying position of HCFA that coverage characterized as an individual policy under state law may nonetheless be subject to group market requirements of the Public Health Service Act, as added by HIPAA, if coverage is provided in connection with a group health plan).

Act (ERISA). However, such plans or funds would retain their "group" tax exclusion benefits under the Internal Revenue Code. Such hybrid treatment (group for tax purposes, individual for regulatory purposes) would be premised on the conditions that (1) only the employer, rather than individual employees, may decide to provide health benefits through defined contribution payments, and (2) such defined contributions must be provided to all employees or all members of a class of employees based on work-related distinctions.[19]

Second, the defined contributions employers make to individual employees in pure DC plans, to be used to purchase individual health insurance coverage, should be allowed to vary on the basis of health status in the event the employer uses an approved risk-adjustment mechanism. That is, employers would be allowed to make larger contributions to workers with poorer health status to offset the higher premiums they would face when they seek to purchase individual coverage. However, state insurance regulators would need to approve this exemption from HIPAA non-discrimination rules.

Third, recent IRS guidance regarding the tax-free rollover status of employer contributions to health reimbursement accounts still does not allow accumulated funds to become vested for other non-health-spending purposes. Nor does it allow employees to contribute their own money to such tax-advantaged accounts. To a large extent, increasing the ceilings for annual rollovers of FSA fund balances, or expanding the availability of MSAs, would bypass most of this problem.

Enhanced Market Pricing Information and Consumer Disclosure Reforms

Once individual consumers are empowered by more equitable and flexible health financing options, how will they obtain sufficient market information to make better choices? Federal government agencies (primarily the Centers for Medicare and Medicaid Services) could help by aggressively disclosing and publicizing, particularly through Internet-based platforms, the various fees for coded medical services authorized under the Medicare program. Physicians and other health care providers should be allowed to cross-reference their own basic Medicare conversion factor with official Current Procedural Terminology (CPT) codes, Resource-Based Relative Value Scale (RVRBS) weighting factors, and geographic practice cost indexes (GPCIs) to effectively make their undiscounted fee schedules for various services and procedures more readily available to cash-paying customers.[20]

Although the American Medical Association (AMA) has been reluctant to allow broad access to some of this "proprietary" information for third-party commercial activities, some version of limited disclosure for consumer information purposes appears to be possible. Indeed, last February, the AMA began offering a free resource on its web site[21] for patients to look up CPT codes and the related Medicare payment information. Patients can enter either the CPT code or the medical procedure description to receive search results that describe the particular CPT service and Medicare fee information by geographic area. The AMA site helps patients research cost estimates of various health care procedures. There is a limit of 10 searches for each individual per day.[22]

Building on this type of information, medical providers should be able to tell potential cash customers, "My conversion factor is x percent of the Medicare conversion factor, and you will be responsible for paying the difference between it and any available third-party means of payment." In this manner, a more competitive market for out-of-pocket health care spending can thrive. In essence, private plans and providers could announce and post voluntarily their uninsured "cash prices" for

[19] The proposed Health Care Account Act of 2001 (H.R. 2658), introduced on July 26, 2001, takes a similar approach. It selectively excludes "health care expenditure accounts" from the definitions of group health plans to which HIPAA group health plan requirements would otherwise apply, but it also treats eligible defined contributions to those accounts as excluded from gross income for federal tax purposes.

[20] Health care payers use CPT codes to categorize physician and other health care services on medical claim forms. Bureau of National Affairs, Inc. "AMA Offers Patients Access to CPT Code Data." *BNA's Health Care Policy Report (*February 11, 2002): 222.

[21] http://www.ama-assn.org/cpt

[22] Ibid.

various diagnosis-related groups (DRGs), CPTs, and other services and procedures as a percentage of Medicare-authorized prices. At that point, further individual bargaining would be possible from this standard baseline.

Market-Driven Deregulation via Competitive Federalism

Empowering consumers with a greater diversity of affordable health benefits choices will require exposing exclusive state health care regulation based on geography to competition from market-friendly regulation across state lines.

Lower-income workers in small firms bear the brunt of excessive state health insurance regulation, because their employers generally are unable to self-insure and, thereby, gain ERISA protection from state benefit mandates, restrictions on rating and underwriting, and other regulatory burdens. In general, increased state regulation has raised the cost of health insurance and limited the range of benefits package design. A wide assortment of small-group regulatory measures imposed by many states during the 1990s failed to improve levels of insurance coverage and, in some cases, priced low-risk consumers out of the small-group market. Various state government regulatory attempts to force low-risk insureds to subsidize high-cost insureds through devices like modified community rating and guaranteed issue often were counterproductive, because they triggered premium spirals that drove younger, healthier, and lower-income workers out of the voluntary insurance market. In other words, state health insurance regulation has been part of the problem, not part of the solution.[23]

Rather than try to solve state-based regulatory failure with a new round of heavy-handed federal rule making or pre-emption, the better route to restoring a market-friendly, consumer-empowering environment at the state level is to facilitate competitive federalism—revitalized state competition in health insurance regulation that reaches across geographic boundary lines. (The closest successful model for such competitive federalism involves corporate law and the business of corporate charters, in which Delaware has specialized and excelled by consistently producing benefits to its "customers"—investors.[24]) Such regulatory competition would limit the excesses of geographically based monopoly regulation. Currently, insurance consumers (at least in the non-self-insured market) are subject to a single state government's "brand" of insurance product regulation. Solely by virtue of where they live, they are stuck with the entire bundle of their home state's rules. Short of physically moving to another state, they are unable to choose ex ante the type of health insurance regulatory regime they might prefer and need as part of the insurance package they purchase.

Competitive federalism could facilitate diversity and experimentation in health insurance regulatory approaches. It would discipline the tendency of insurance regulation to promote inefficient wealth transfers and promote individual choice over collective decisions driven by interest group politics.[25] In short, it would improve the quality of health insurance regulation, thereby enhancing the availability and affordability of health insurance products.

Insurers facing market competition across state lines would have strong incentives to disclose and adhere to policies that encouraged consumers to deal with them. Employers and individuals purchasing insurance would migrate to state regulatory

[23] See, for example, Frank A. Sloan, Christopher J. Conover, and Mark A. Hall. "State Strategies to Reduce the Growing Numbers of People without Health Insurance." *Regulation 22* (3) (1999): 24–31; Melinda L. Shriver and Grace-Marie Arnett. "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations." Heritage Foundation Backgrounder No. 1211, August 14, 1998, Washington, DC; Employment Roundtable. "Personally Owned Health Insurance Policies: A Solution for the New Economy?" Washington, DC, March 2001; Jensen and Morrisey, op cit.

[24] See Roberta Romano. "Law as a Product: Some Pieces of the Incorporation Puzzle." *Journal of Law, Economics, & Organization 1* (2) (1985): 225–83; Jonathan R. Macey. "Federal Deference to Local Regulators and the Economic Theory of Regulation: Toward a Public-Choice Explanation of Federalism." *Virginia Law Review 76* (March 1990): 265–91.

[25] Tiebout pioneered an economic theory of federalism that argued that competition among local jurisdictions allows citizens to match their preferences with particular menus of local public goods: Charles M. Tiebout. "A Pure Theory of Local Expenditures." *Journal of Political Economy 64* (5) (1956): 416–24. Qian and Weingast noted that inter-jurisdiction competition, along with decentralization of information and authority, can provide credible commitment to secure economic rights and preserve markets: Yingyi Qian and Barry R. Weingast. "Federalism as a Commitment to Preserving Market Incentives." *Journal of Economic Perspectives 11* (4) (1997): 83–92.

regimes that did not impose unwanted mandates but, instead, fit the needs of their consumers. State lawmakers would become more sensitive to the potential for insurer exit. At a minimum, interstate regulatory competition would provide an escape valve from arbitrary or discriminatory regulatory policies imposed at either state or federal levels. Key design requirements for regulatory competition in health insurance would include:

1. Only one sovereign has jurisdiction over a particular set of health insurance transactions, and its law controls the primary regulatory components of the regime governing them. Other states provide regulatory reciprocity (also known as the "principle of mutual recognition" in the European Union), by respecting and enforcing that state's insurance charter and its accompanying rules. Such reciprocity works through private arbitrage of jurisdictional competition, rather than politically mandated harmonization that suppresses competition.

2. Health insurers can choose their statutory domicile, or otherwise determine the applicable forum and applicable law, and make it part of the purchasing option they present to consumers. Insurers and their consumers can exercise the right of free exit: they can vote with their feet and their pocketbooks. Insurers can choose their domiciles, the markets where they prefer to operate, and the bundle of laws and regulations attached to the products they sell. They can relocate to alternate jurisdictions at relatively low cost. Consumers may choose not only the state in which they live but also the legal rules attached to the insurance products they buy.

3. States must receive some benefits, such as tax revenues, from competing in the production of specific laws and regulations that reduce insurers' business costs and increase the value of insurance products. Conversely, states also must feel within their own borders a sufficient number of any negative consequences of the regulatory regimes they choose to adopt and "export" to consumers in other states.

4. Competition for the marginally informed consumer must operate to protect other consumers who are not aware or informed of the particular regulatory regime.

5. Rather than present a single set of contract terms on an all-or-nothing basis, insurers can offer consumers a menu of alternative policies that are priced to reflect different regulatory approaches.

6. Solvency regulation should remain decentralized and kept at the state level, to avoid federal domination over other regulation in the name of protecting consumers and taxpayers. Regulatory competition for insurance product design, pricing, and pooling could be accommodated within the current state-based guaranty fund system in a manner that limits an individual state's opportunities to impose costs on other jurisdictions.

Several mechanisms or paths could lead to vigorous interstate competition in health insurance regulation. A more indirect, but sustainable, approach would involve strategic use of choice of forum clauses, and perhaps choice of law clauses, in health insurance contracts. Insurers would condition sales of a particular policy on a consumer's consent to the designated litigation forum. That forum would be matched to the state whose regulatory law was selected. This choice of forum would need to be adequately disclosed and executed at the beginning of the contractual period, not just at the time of litigation. Insurers could increase the likelihood that the agreement would be enforced and regulatory competition enhanced by linking the designated forum to their company's domicile—rather than to the site of the sales transaction.[26]

Federal law could provide some shortcuts—such as a statute mandating enforcement of choice of forum contracts under the commerce or full faith and credit clauses of the Constitution. Congress also could provide uniform disclosure requirements for choice-of-forum and the insurer's domicile in insurance contracts.

A more direct federal statutory approach might set an "insurer domicile" rule, in place of a "site of transaction" rule, for determining applicable state law and regulatory authority—at least as a default rule for multi-state transactions where the respective parties do not otherwise designate operative

[26] Larry E. Ribstein and Bruce H. Kobayashi. "A State Recipe for Cookies: State Regulation of Consumer Marketing Incentives." American Enterprise Institute Federalism Project Roundtable, January 30, 2001 (www.federalismproject.org/masterpages/ecommerce/cookies.pdf).

law. For example, Rep. Ernest Fletcher (R-KY) recently introduced the "State Cooperative Health Care Access Plan Act of 2002" (H.R. 4170), which would authorize a health insurer offering an insurance policy in one primary state (the primary location for the insurer's business) to offer the same policy type in another secondary state. The product, rate, and form filing laws of the primary state would apply to the same health insurance policy offered in the secondary state.[27]

Another route to interstate competition in insurance regulation might be built on decisions by individual states to grant regulatory "due deference" to determinations by out-of-state insurance regulators that a particular insurance company is qualified to conduct such business. Once an insurer submitted evidence of good standing in its domestic jurisdiction and (if different) in the jurisdiction where it conducts the largest share of its health insurance business, it would qualify for licensure in the state granting such regulatory deference.[28]

Involving Congress in structuring interstate regulatory competition may be necessary to defuse threats of retaliation and exit restrictions by individual state insurance regulators. However, it remains unlikely that Congress would relinquish a great deal of current and future regulatory authority over health insurance (HIPAA; mandates for mental health parity and minimum maternity stays in the hospital; proposed patients bill of rights legislation [PBOR]) without asking for something in return. For that reason, the contractual choice of forum approach would be preferable to other more targeted statutory fixes requiring costly political side payments.

Any move to full-fledged regulatory competition in health insurance, whether attempted through a legal or a legislative strategy, will require mobilization of political constituencies that see its benefits and need them. The most likely future candidates for reinvigorated state regulatory competition might well be large, self-insured, multi-state firms. Most versions of proposed PBOR legislation would target them for the greatest liability risks, particularly if those firms administer their own workers' health benefits in-house. If enacted into law, PBOR also would strip away many of the benefits of current ERISA protections against state regulation by imposing a multitude of new federal mandates on self-insured companies. (As of this writing, it appears unlikely that negotiators ultimately might revive and revise the latest version of such proposed legislation to ease some of the new liability burdens on large, self-insured employers by transferring lawsuits against them to federal court.) Multi-state, self-insured firms still may seek the uniformity of a single regulator, but seeking exclusive regulation at the federal level may not provide a deregulatory haven much longer. If large firms begin to see self-insured status as more of a liability-increasing risk than a regulation-reducing benefit, they may consider the virtues of linking their plans to a single market-friendly regulatory regime at the state level. If state insurance regulatory systems could compete on an interstate basis, the better ones might find a new customer base in multi-state firms seeking consolidated regulation of fully insured products at the state level.

Another possible block of customers for competitive federalism-style insurance regulation includes purchasers of individual insurance on the Internet. The current lines of regulatory jurisdiction for Internet sales remain fluid. Congress might consider a special carve-out to minimize the growth of new regulatory burdens on this promising channel of distribution. Matching regulatory jurisdiction to an insurer's state of incorporation might simplify the regulatory branding for Internet insurance products. It also would allow an insurer to offer potential Internet-based purchasers a more uniform insurance product, regardless of where they live. Recent

[27] See also Employment Roundtable, op cit., pp. 20–21.

[28] Regulators in secondary states would be most likely to treat proof of licensure and good standing in the primary state as prima facie evidence of qualification for licensure in the secondary state, while still requiring additional routine documents and fees and compliance of the primary state's insurance department with broadly accepted accreditation standards, such as those maintained by the National Association of Insurance Commissioners. (For one creative "draft" proposal outlining how regulatory due deference might operate at the state level, see Lawrence Mirel. "Regulatory 'Due Deference': A Proposal for Recognition and Deferral to Fellow Insurance Regulators under Certain Conditions." Exposure Draft. Commissioner of Insurance and Securities for the District of Columbia, January 1, 2002.) Initially, an individual state's decision to grant regulatory due deference would be similar to a declaration of unilateral free trade in health insurance products. The state would be eliminating or reducing its own regulatory restrictions on out-of-state insurance to benefit its citizens and to provide a model for other states to emulate.

individual insurance price quotes for Internet-marketed products suggest that such distribution already has great potential to make low-cost insurance more available to lower-income consumers.

An additional block of potential buyers for competitive federalism-style health insurance could be sponsors of voluntary purchasing coalitions. To gain a firmer foothold in the health insurance marketplace, buyers' groups will need to find state-based regulation that does not overpower them with rating restrictions and pooling requirements (to the extent they are not pre-empted by other federal legislation). These groups also are likely to operate beyond a single state's boundaries, and they would prefer dealing with a single insurance regulator.

Finally, if optional federal tax credits are made available to purchasers of non-ESI policies, Congress could consider crafting special regulatory treatment for policies serving this new clientele.

Of course, proposing interstate competition in state health insurance regulation will face predictable "race to the bottom" warnings. However, those who prefer the existing set of choices within the existing health insurance regulatory system can continue to use them. Other consumers who believe there are advantages in new and different regulatory approaches should be allowed to try them.

Reputational concerns will provide both constraints and incentives for the choice of regulatory regimes by established insurance firms. There is little to be gained on a long-term basis in contracting for a law and forum that many consumers are likely to know unduly favors insurance sellers over buyers.

Normal competitive pressure would discourage private insurers from repeatedly switching their state insurance regulator on an opportunistic, short-term basis. Insurers would be more likely to issue a credible promise not to remove to another state, in order to reduce doubts about the enforceability of certain provisions of its insurance contracts.[29] By accepting this restriction voluntarily, a private insurance company might improve its market value. Insurers also would tend to incorporate in states that had an established tradition of regulatory stability and in states whose economy was more dependent on the insurance industry.

State regulators could coordinate their law enforcement activities to deal with interstate problems. They also could require compliance with the standards of a centralized body to assist necessary uniformity in certain areas. Or Congress could establish a default rule for enforcement of certain actions (such as those involving consumer fraud or other improper market conduct) that affect consumers in a secondary state but involve insurance policies regulated by a primary state. The rule would authorize insurance regulators in that secondary state to treat the insurer involved as if it were primarily licensed there.[30]

Defenders of the current regulatory structure and skeptics of regulatory competition need to answer the "Compared to what?" challenge. They cannot just assume that a hypothetically perfect, well-designed system of more and more state (or federal) health insurance regulation will materialize in the future. They need to demonstrate its measurable benefits over a more decentralized system of regulatory competition—a system much more likely to deliver the contractual assurances, services, and features for which buyers are willing to pay.

After all, we have already been running a different race to the "bottom" with too much regulation. The losers end up uninsured—because they can't afford coverage or refuse to overpay for it. The race to the "market top" needs a full field of state regulators running in each other's markets.

Summary

The tax incentives and deregulatory initiatives above would be aimed at increasing overall insurance coverage levels for catastrophic protection, encouraging more stable and longer-term private insurance arrangements, providing a better match between individual consumer preferences and available products, and expanding the pool of personal savings available to finance more routine and discretionary

[29] Henry N. Butler and Jonathan R. Macey. "The Myth of Competition in the Dual Banking System." *Cornell Law Review 73* (May 1988): 677, 715.

[30] See, for example, the State Cooperative Health Access Plan Act of 2002 (H.R. 4170): § 101.

health care spending choices. New voluntary pooling options also may lower the administrative costs and improve the qualitative choices available to certain health care purchasers employed by small firms, self-employed, and/or lacking access to employer-sponsored insurance coverage. The overall objective is to help make less-comprehensive levels of private insurance coverage more available and more affordable for more customers.

Safety Net Reforms

The above reforms focus in large part on restructuring and expanding financial assistance via the tax code to empower and provide incentives to *taxpayers* to purchase at least basic levels of catastrophic health insurance coverage. The additional combination of deregulatory reforms, personal savings incentives, and reduced subsidization of discretionary health spending would increase the availability of more affordable health care options for all purchasers. Nevertheless, lower-income individuals and families ineligible for Medicaid coverage still would need to rely to a great extent on the mixture of safety net mechanisms (state uncompensated care funds, public hospitals, community health centers, mandated emergency room care, and other uncompensated care provided by private hospitals and physicians) that provide a market for "free care."

The uninsured in general pay out-of-pocket for only about one-third of the care they receive. Even more of that charity care is available to low-income uninsured individuals in particular. According to Herring, high-income uninsured individuals receive more than half (53 percent) of their medical care in the form of charity care, whereas low-income uninsureds receive just over two-thirds (68 percent) as free care. The average uninsured person consumes at least 50 percent, and perhaps as much as 60 percent, of the annual health care used by the average insured individual.[31]

In deciding whether it's best to subsidize insurance coverage or additional "free" health care for the low-income uninsured, several points stand out. The current market for charity care operates quite rationally in mimicking the effects of private catastrophic insurance policies. The proportion of health care paid out-of-pocket by the uninsured decreases considerably as utilization and total "spending" increases. Proportionately more charity care is available for uninsured individuals who incur larger medical expenses. And the low-income uninsured with high medical bills (above $10,000) pay about half as much out-of-pocket for their care as do high-income uninsured individuals with similarly sized bills. (The low-income uninsured with such high bills receive 90 percent of their care for free.)[32]

At the same time, availability of charity care for uninsured individuals has a modest negative effect on their decision to purchase private health insurance. In effect, the supply of free care lowers the "reservation price" value of insurance for the uninsured when they consider the *net* cost to them of paying for insurance premiums versus remaining uninsured. If the supply of free care expands, tax credit subsidies will need to become even larger to induce the uninsured (particularly those with low incomes) to purchase insurance.

However, the relative crowd-out effects of expanded free care that reduce insurance levels are modest compared to its benefits in improving a low-income uninsured individual's direct access to health care (as opposed to health insurance).[33] This suggests strongly that, dollar-for-dollar, investing in safety net assistance to the low-income uninsured is more effective and productive than trying to coax them to purchase health insurance with tax subsidies.

Although increased federal subsidies to local uncompensated care pools and to community health centers may bolster those important components of the overall safety net, two higher-priority items should be targeted first: financial assistance to high-risk pools for the medically uninsurable, and expanded tax incentives for charitable giving that helps deliver health care services to the low-income uninsured.

[31] Herring, 2001, op cit., pp. 9–10; see also Herring, 2000, pp. 27–37.

[32] Herring, 2001, p. 10.

[33] Ibid., pp. 29–30.

Medicaid Coverage for State High-Risk Pools

Medically uninsurable individuals represent a small percentage of the uninsured population (roughly no more than 1 percent to 2 percent of the uninsured have ever been denied health coverage for medical reasons).[34] But they present the strongest case for public assistance. To some degree or another, at least 30 states currently operate high-risk pools that make insurance coverage available to them and subsidize their premiums.

States with well-structured and adequately financed high-risk pools are more successful in keeping their individual health insurance markets competitive and insurance rates affordable. Such pools allow the individual insurance market to operate efficiently, while carving out for special treatment those high-cost individuals who are beyond the capacity of the individual market to handle on an unsubsidized basis.[35]

However, not all state high-risk pools are adequately financed (ideally, the funding should come from general revenues rather than through taxes on insurers within the state), and many states do not provide such subsidized coverage at all. Using the rationale that the "medically uninsurable" (at least to the extent that the unsubsidized price to insure them privately far outstrips their ability to pay) should be considered "medically needy," mandatory Medicaid coverage and matching federal assistance should be extended to this class of beneficiaries, provided that the funds are channeled through state-operated high-risk pool programs that meet certain minimum criteria (for example, premium ceilings, waiting periods, rejection by at least one insurer, catastrophic conditions allowing automatic pool acceptance without prior carrier rejection) already in practice, but not "new" ones. The scope and scale of this Medicaid-financed high-risk pool coverage for the medically uninsurable would be capped at an upper ceiling that equals the higher amount of all individuals in a state facing private insurance premiums that are at least 200 percent of standard rates (plus those who cannot obtain any coverage at all, for medical reasons) or 2 percent of all people covered in a state's individual insurance market.

Citizen Appropriations for Charitable Health Care

To bolster financing for charitable safety net care and ensure that it is delivered with private-sector efficiency, a new 100 percent, dollar-for-dollar federal income tax credit (above the line) would be provided for certain charitable contributions to provide health care services to the low-income uninsured. These "citizen appropriations" would be modeled in part on the Arizona tax credit for education "scholarships."[36] The maximum individual credit amount allowed would be no greater than 10 percent of an individual's federal income tax liability in a given tax year. Eligible donations would have to be made to approved organizations that provide health insurance coverage, health care services, or payment of medical bills to uninsured individuals who are not eligible for optional federal health tax credits or Medicaid assistance. Organizations eligible to receive the donations must either be a non-profit, in accordance with section 501(c)(3) of the Internal Revenue Code, or, in the case of hospitals, physicians, insurers, and other health care providers that wish to receive direct donations, a separate non-profit subsidiary created by them to receive and distribute such funding. Eligible organizations could spend only as much of their donations as they could document was directed toward paying the health care expenses of qualified uninsured individuals. Taxpayers could designate the institution to which their donation would be directed, but they could not pinpoint the individual beneficiary.

[34] Karen Beauregard. "Persons Denied Private Health Insurance Due to Poor Health." Agency for Health Care Policy and Research publication no. 92-0016. Rockville, MD, December 1991; Pauly and Herring, op cit., pp. 88, 90–91.

[35] Elizabeth White. "Risk Pools Aim to Cover Uninsurable, Stabilize Insurance Markets." BNA's Health Policy Report, August 27, 2001, pp. 1338–41; Conrad F. Meier. "Extending Affordable Health Insurance to the Uninsurable." Heartland Policy Study No. 91, August 27, 1999.

[36] See, for example, Carrie Lips and Jennifer Jacoby. "The Arizona Scholarship Tax Credit: Giving Parents Choices, Saving Taxpayers Money." Washington: Cato Institute Policy Analysis No. 414, September 17, 2001; Lisa Snell. "The Arizona Tax-Credit Program Paradox." Reason Public Policy Institute Policy Update 18, April 4, 2002.

Thinning Out the Emergency Room—Rethinking EMTALA

Hospital emergency rooms increasingly are plagued by overcrowding, unfunded care deficits, and arbitrary federal regulatory mandates. Behind a good many of those problems is the Emergency Medical Treatment and Active Labor Act (EMTALA), originally a largely symbolic law but now one with increasingly pernicious consequences.

EMTALA essentially prohibits discrimination against individuals seeking treatment (frequently high-cost) in hospital emergency rooms based on ability-to-pay criteria. It has been interpreted and expanded through the past decade to essentially provide broad, unfunded access not just to emergency care, but, potentially, inpatient care as well. As David Hyman notes, hospital emergency room personnel cannot delay treatment or examination to inquire about patients' ability to pay or their insurance status.[37]

As an unfunded federal mandate imposed on hospitals, EMTALA has created free-rider problems. First, managed care organizations cut back on emergency care coverage, and then their insured patients bypassed their health plans' contractual restrictions on access to emergency departments and arrived there for "free treatment" anyway. By the late-1990s, EMTALA essentially mandated access to 24-hour, just-in-time, emergency care at levels well above what many insured individuals were willing to pay for in their managed care plan contracts. With hospital emergency departments already disproportionately serving patients covered by Medicaid and those who are uninsured, increasingly unable to "make up their losses on volume," and finding their proportion of paying insured patients declining, EMTALA's unrestricted entitlement for utilization up to ER capacity provided strong incentives for hospitals to constrain, rather than expand, their emergency department capabilities. As too many patients lined up for federal free lunches in the ER, overcrowding, queuing, and declining quality of care hurt the uninsured most.

A first-stage remedy would be to repeal EMTALA's application to insured patients. ER personnel should be given leeway to sort prospective patients initially into "insured" versus "uninsured" categories, with the former then explicitly informed that they will be held personally responsible for unreimbursed care and asked to provide modest refundable deposits (returned in the event of true emergencies that are eligible for health plan reimbursement).[38]

Second-stage relief to ER overcrowding would involve new federal assistance to *all health care providers* delivering disproportionate shares of uncompensated *emergency* care to the *uninsured* (in effect, DSH-E, or disproportionate share-emergency care, rather than the current DSH, or disproportionate share, payments that are made to providers with high levels of services to lower income patients), instead of continuing to impose unfunded emergency care mandates. Reimbursement would be pegged to Medicaid payment levels, but it would be based only on actual levels of otherwise uncompensated care to the uninsured.

Beyond limiting EMTALA emergency room mandates to individuals without insurance coverage, we also would consider allowing emergency care providers to charge uninsured individuals who, upon preliminary screening, present no obvious emergency symptoms a refundable copayment at the time of such emergency room care (limited in amount, returned in the event that ER staff later certifies that an emergency condition in fact existed, and federally subsidized for low-income individuals not otherwise eligible for Medicaid or federal tax credits).

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[37] This section draws heavily on the work of David A. Hyman. "Patient Dumping and EMTALA: Past Imperfect/Future Shock." *Health Matrix: Journal of Law-Medicine 8* (Winter 1998): 29–56.

[38] For evidence that increased cost sharing could discourage patients from inappropriately using hospitals' emergency departments, see Kevin F. O'Grady, Willard G. Manning, Joseph P. Newhouse, and Robert H. Brook. "The Impact of Cost Sharing on Emergency Department Use." *The New England Journal of Medicine 313* (August 22, 1985): 484–90 (finding that a 25-percent level of cost sharing deterred emergency department utilization for less serious conditions but did not deter utilization for more serious conditions). See also Joe V. Selby, Bruce H. Fireman, and Bix E. Swain. "Effect of Copayments on Use of the Emergency Department in a Health Maintenance Organization." *The New England Journal of Medicine 334* (March 7, 1996): 635–41 (concluding that a small co-payment resulted in a 15 percent reduction in emergency department utilization but did not affect conditions classified as "always an emergency").

Medicaid Opt-Out Vouchers for Other Private Insurance Coverage

To help provide a transitional step from Medicaid coverage to longer-term private coverage under the various options outlined above, federal Medicaid waiver authority would be expanded for states that already provide private managed care alternatives to Medicaid fee-for-service coverage and use capitated per-beneficiary payments to do so. States could allow individual Medicaid-eligibles (not including the blind and disabled, or the medically needy elderly) to claim their "share" of annualized capitated payments as a private health insurance voucher. This option would be at the initiative of beneficiaries (no mandatory assignment). These opt-out beneficiaries, whose Medicaid eligibility would be annualized to reduce administrative costs and complexities, then could use the vouchers to purchase other eligible forms of HIPAA-qualified private insurance coverage.

States would be allowed to waive certain mandatory Medicaid benefits package requirements for these private insurance alternatives to allow beneficiary cost sharing and economizing incentives. For example, private opt-out plans could combine greater cost sharing with first-dollar coverage of preventive care services—most likely two annual primary care physician office visits. Plans that combine high-deductible catastrophic coverage with individual health spending accounts would be specifically authorized. Private opt-out plans also would be authorized to provide rebate incentives for beneficiaries using covered services in amounts totaling less than 30 percent of annual premiums, or for those not using emergency room benefits, in a given year. Apart from this enhanced cost-sharing flexibility, minimum covered benefits would be similar to those required for the optional federal tax credits, as described previously.

States using this waiver authority could choose to risk adjust voucher amounts for participating beneficiaries, but they would not be required to do so.

Coverage/Eligibility

Apart from existing Medicaid program criteria for coverage of the non-elderly, non-disabled poor, eligibility is not directly pegged to income. Tax credit assistance requires federal tax liabilities, but it is provided proportionately (30 percent of eligible expenses) rather than laddered or phased out according to one's income level. It would not be available to individuals taking advantage of the current tax exclusion for ESI (no double-dipping). MSA options are available to anyone who purchases HIPAA-qualified catastrophic health insurance (ideally with fewer restrictions on the permissible range of deductible levels). Tax-free rollover treatment of year-end FSA balances is available to employees offered and using FSA benefits in ESI plans. Any employer may offer a defined contribution health benefits plan with individual health savings accounts, provided the employer pays for the health insurance (either directly or when presented by a participating employee with a request for reimbursement of a paid insurance coverage invoice).

Safety net assistance via "citizen appropriations" charitable tax credits will be distributed according to the rules set by eligible non-profit intermediaries. Although it theoretically could be distributed directly to the insured (for example, to subsidize the employee share of ESI premiums), standard priority setting as well as likely Internal Revenue Service (IRS) rules for charitable purposes would make that unlikely. EMTALA-mandated "free" emergency care would be limited to the uninsured. The only mandatory coverage would be that under current law that is not otherwise eliminated above (Medicaid, Medicare, military care, and other miscellaneous federal health programs).[39] Purchase of private coverage would remain voluntary, but be more widespread as the "value" of that coverage improves. Individuals who believe they can improve their overall well-being by spending their money on other items than health insurance (for example, investment in education has a higher payoff in terms of improved health outcomes than does the purchase of health insurance, all things being equal) should remain free to do so. The ultimate objective is to

[39] Reform of those public programs is outside the immediate scope of this paper. For the author's thoughts on those issues, see Tom Miller. "Public Health Care." In *Cato Handbook for Congress: 108th Congress.* (Washington: Cato Institute, forthcoming 2003).

improve health outcomes for more people, and, secondarily, to facilitate their access to necessary *health care.* Greater health insurance coverage is only one of several means to accomplish that objective, not an end in itself.[40]

Opportunities to accumulate long-term savings in MSAs, FSAs, individual health savings accounts within two-tiered DC plans, and even Medicaid opt-out rebates would provide a further financial buffer to weather insurance coverage disruptions during transitional periods (job switches, unemployment, early retirement, welfare to work). Labor market competition should limit incentives for employers to abandon current ESI coverage offers, although employers may need to restructure their plans to deal with federal tax credit competition.

Subsidies

The primary subsidies for health insurance and health care spending would remain tax subsidies, unless and until it is politically feasible to pull all of them up from the tax code by their roots and branches.[41] Individual states may continue to set different income phase-out levels for Medicaid assistance. High-risk pool subsidies are pegged to the degree by which individual insurance premium quotes exceed standard rates, although states may wish to consider setting some secondary income criteria that link eligibility for such subsidies to private insurance premium levels that exceed a particular minimum percentage of one's annual income.

The optional federal tax credit is designed to "crowd in" workers who seek alternatives to current ESI offers, as long as they are willing to make the necessary cost-sharing trade-offs. The 30 percent tax credit is also designed to be more appealing to workers in lower marginal income tax brackets (the 15 percent bracket, plus a discounted portion of the full 15.3 percent employer/employee FICA payroll tax), and less appealing to higher-income workers who would benefit more from the current tax exclusion for ESI coverage.

Various deregulatory reforms that open up new private coverage options might crowd out some portion of current ESI coverage, to the extent that the former offer higher-value alternatives. Covered individuals currently benefiting disproportionately from regulatory cross-subsidies might need to rebalance their personal health spending with their personal health care costs in a more competitive, risk-sensitive pricing environment.

Removing access to free emergency room care (under EMTALA mandates) from insured individuals would reduce "free riding" by managed care plans, restore and perhaps expand emergency care capacity, and improve access to emergency care for the uninsured.

The optional federal tax credit is based on one's previous calendar year federal tax liabilities, authorized to be advanceable and transferable, and able to be administered through payroll deduction and/or list billing—all to reduce cash flow problems. Limited forms of multi-year income averaging may help to address beneficiary concerns about year-end reconcilability and recapture.

The Medicaid opt-out vouchers provide a slight opportunity to mainstream low-income beneficiaries with non-subsidized people in private insurance plans. However, there is nothing wrong with a little "welfare" stigma to the extent that it provides incentives to individuals to seek higher-paying employment, better insurance coverage, and economic independence. The medically uninsurable in state high-risk pools, on the other hand, are only partially subsidized because they still would pay approximately 150 percent to 200 percent of standard insurance rates.

Most of the proposed subsidies herein would come from the tax expenditure side of the federal budget ledger. Federal matching payments for state high-risk pools and disproportionately mandated emergency room care to the uninsured would flow through the Medicaid entitlement, rather than the annual appropriations, process.

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[40] See Cato Institute. "Will More Health Insurance Improve Health Outcomes?" Policy Forum, June 19, 2002 (http://www.cato.org/events/020619pf.html).

[41] See Tom Miller. "Health Care." In *Cato Handbook for Congress: 107th Congress.* Washington: Cato Institute, 2001, pp. 311, 313–17.

Financing

Necessary funding would be acquired through a combination of spending reductions within both current federal health programs and other federal non-health programs (a lengthy set of recommended budget cuts is available on request from the Cato Institute, and Congress continues to supply new opportunities to expand it on a regular basis), as well as reprogramming of current Medicaid spending. To the extent that the total amount of reduced federal tax revenue (due to individual tax credits) still remains greater than the reduced expenditure levels, we suggest that it would represent a more productive form of publicly held federal government debt than other, much larger amounts of currently "implicit" long-term debt for health care expenditures (Medicare). Incentives aimed at reducing the long-term trend in the growth rate of health care costs also would help any given level of spending to deliver more, and better, health care.

A portion of funding for high-risk pools would shift from the state level to the federal government, and the overall amount of such funding for assistance to the medically uninsurable would be likely to increase with more liberal eligible criteria.

Providing federal disproportionate share assistance to emergency care providers for the uninsured would shift some of that burden from the private sector (unfunded EMTALA mandates) to federal taxpayers.

We view private ESI benefits as job-based compensation by non-wage means. In that sense, the employee bears the ultimate cost of such insurance. Carving back regulatory cross-subsidies and reducing the tax bias favoring employer group insurance coverage would better match individual workers' personal health care consumption decisions with what they are willing and able to pay.

Insurance and Risk

We remain unperturbed by hypothetical concerns about adverse selection and risk segmentation in a more competitive, market-based private health insurance system. There is little evidence that individuals and families can identify and anticipate most of their future medical expenses in ways their potential insurers cannot. A recent study by Cardon and Hendel finds little empirical evidence of information asymmetries, market failure, and adverse selection in health insurance markets.[42] Differences in health expenditures between the insured and uninsured are mostly due to observable differences in demographics (age, gender) and price sensitivities (higher-income workers capture more tax subsidies for insurance coverage), rather than unobservable factors related to health status.

Private insurers do not need to remain helpless and clueless regarding potential adverse selection problems. In competitive markets, they may use a number of tools: set periodic limits on plan switching, vary premiums according to the amount of insurance purchased, underwrite and rate based on risk categories, create more homogeneous risk pools, or rely on the law of large numbers to diversify risks in large pools. Consumer inertia and individual differences in aversion to risk further limit the applicability of adverse selection theory to the real world.

Many difficulties we observe in health care insurance markets are due to government intervention rather than adverse selection or other market failures. If insurers are not allowed to charge different premiums to different risks, price predicted risk appropriately, and match their policy configurations to market demands, they will be more likely to resort to higher uniform prices, less savory practices like excluding or discouraging coverage of high risks, and, ultimately, market exit. Cream skimming

[42] James H. Cardon and Igal Hendel. "Asymmetric Information in Health Insurance: Evidence from the National Medical Expenditure Survey." *The Rand Journal of Economics 32* (3) (2001): 408–27. See also Stephen H. Long, M. Susan Marquis, and Jack Rodgers. "Do People Shift Their Use of Health Services Over Time to Take Advantage of Insurance?" *Journal of Health Economics 17* (1) (1998): 105, 112–15. Long et al. find little support for the hypothesis that people anticipate changes in their insurance status and arrange their health care consumption accordingly. The authors also find no evidence that people choose to purchase or drop insurance coverage in anticipation of change in their overall health care needs and conclude that insurer selection is an unlikely explanation for this failure to find quantitatively important transitory demand. However, they observe that recent state reforms aimed at eliminating or limiting some insurer restrictions on coverage of pre-existing conditions ironically might increase the ability of patients to adjust their treatment patterns for chronic conditions in anticipation of insurance changes.

(selecting only the best risks) becomes the insurers' mirror image of adverse selection by insurance customers. Political interventions fail to alleviate underlying differences in risk across customers or eliminate insurers' knowledge of such differences. They only force insurance companies to cope in inefficient ways and create new problems.

It is preferable to allow private insurers to do what they do best—evaluate risk and price it accordingly—and then deal with remaining outlier problems (for example, the medically uninsurable) through explicit, transparent public subsidies rather than more camouflaged regulatory cross-subsidies. We should separate support for societal objectives of income redistribution and protection against prohibitively expensive, but predictable, health risks from the competitive operations of commercial insurance markets.

Health status information is most likely to be asymmetric when it is scarce and costly. While government mechanisms prefer to ignore, hide, or shift those information costs, markets create proper incentives to discover efficient ways to signal relevant private information and put it to use.[43]

Deregulating insurance choices and providing greater tax parity for all insurance purchasers can fill the real gaps in private insurance coverage, by providing breathing room for further market innovations, such as new forms of voluntary risk pooling and long-term insurance contracts. The growing availability of online health information and insurance products further strengthens the case for empowered consumers.

Market mechanisms cannot eliminate every unfortunate human experience in health care access, affordability, and quality. Private charity and a backup safety net of transparent, direct subsidies have necessary roles to play. Unlike centralized government "solutions," markets do not promise perfect outcomes, just better ones.

[43] Stephen Shmanske. "Information Asymmetries in Health Services: The Market Can Cope." *The Independent Review 1* (2) (1996): 191–200.

Administration and Regulation

In most cases, administration and regulation of health insurance arrangements would remain predominantly at the state level (subject to the ERISA pre-emption for self-insured employer group plans, and new pre-emption protections for certain voluntary purchasing pools and insurance purchased with new federal tax credits). Consumer flexibility, rather than state flexibility per se, would be increased through greater interstate regulatory competition and arbitrage (competitive federalism). The Internal Revenue Service and the Treasury Department would play a large role in administering new forms of tax-code-based assistance and in regulating charitable care intermediaries handling "citizen appropriations" tax credits used for charitable health care purposes.

High-risk pools for the medically uninsurable should continue to be administered by states, but some degree of federal monitoring would creep in as a corollary to matching federal Medicaid funds.

A new federal administrative apparatus (hopefully modest) would be needed to handle federal matching payments for disproportionate uncompensated emergency room care provided to the uninsured.

Benefits

Apart from a generic list of the minimum "types" of benefits that must be included in private insurance eligible for optional federal tax credits, benefits could vary widely for different covered individuals. The most important component of such variation would be in the range of cost-sharing mechanisms and levels. Deregulated health insurance options should operate as "magnet health plans" that increasingly draw consumers away from more traditionally regulated insurance plans (in particular, fully insured employer group plans still subject to substantial state-level regulation).

Fit and Feasibility

The new system is designed to be evolutionary, based on incentives and market-opening opportu-

nities for a wider range of health care financing and delivery alternatives. The respective market shares for the latter would be determined by the preferences of empowered individual consumers, controlling more of their own money and responsible for the consequences of their decisions. We do not tear up the employer-based system, but we subject it to new competition on a more level playing field. To be clear, most of the "new" economic signals would point in the direction of greater cost sharing, less-comprehensive insurance coverage, and more individual consumer responsibility. But consumers seeking more security or more predictable long-term arrangements would be able to join together in particular health financing mechanisms that facilitate those preferences. (They just would find it harder, through political means, to force others to disproportionately subsidize their particular tastes.)

Individual workers, more so than employers, would be presented with expanded voluntary options rather than political mandates. The pace of change largely would be determined by their decentralized, pluralistic choices.

The current climate of annual double-digit percentage increases in health care costs, dissatisfaction with the mature version of managed care, and remaining political resistance to centralized command-and-control mechanisms points to greater acceptance of the last remaining, relatively unexplored health care reform option—putting choices back in the hands of individual consumers and competitive free markets.[44]

Equity

To a larger degree under the new system, you would get what you pay for, unless someone else wanted to pay for it voluntarily on your behalf. Income redistribution issues should be debated separately and resolved in the larger political arena, while we finally allow health insurance markets to operate more efficiently for the purposes for which they are best suited. The optional federal tax credit, designed as an uncapped percentage of insurance costs, is better adapted for coping with regional market cost differences as well as variations in the ex ante risk profile of individual customers.[45]

By focusing on safety net assistance that delivers health care, rather than health insurance, aid to those most in need could be targeted better, and at lower cost.

Quality of Care and Non-Financial Access

The ultimate arbiter of the quality of care should be the person who receives it and pays for it. Patients have more at stake regarding quality than any other party in the health care system. By more effectively combining consumption of care with its purchase (that is, less third-party payment), we are more likely to arrive at the optimal mix of access, cost, and quality.

A necessary role remains for separately targeted public assistance for special or vulnerable populations. But the proposed experiment in citizen-directed appropriations for charitable care via dollar-for-dollar tax credits is more likely to deliver legions of new, involved players on the compassion front, who actually know the type of people they are helping and care deeply about them.

The new system increasingly would distribute medical resources toward the places where individual consumers wish them to go, instead of where various medical providers, health industry vendors, and "enlightened" experts prefer to receive them. "Patient-directed" and "consumer-driven" health care would operate under new sets of directions. ■

[44] See James C. Robinson. "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." *Health Affairs* (web exclusive March 20, 2002) (http://www.healthaffairs.org/WebExclusives/Robinson_Web_Excl_032002.htm).

[45] In using a 30 percent tax credit that is proportional to the cost of one's health insurance premium, instead of a fixed-dollar tax credit, we place greater emphasis on assisting a smaller number of higher-risk individuals in financing insurance coverage, rather than aiming simply to sign up as many lower-risk individuals as possible for less expensive, but perhaps also less necessary, insurance coverage. For a discussion of the trade-offs between these different approaches to insurance subsidies, see Mark Pauly, Bradley Herring, and David Song. "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured." NBER Working Paper No. 8457. Cambridge, MA: National Bureau of Economic Research, September 2001, p. 17.