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BOB DOLE'S BILL — BETTER BUT STILL BAD

Senator Dole has introduced a health care reform proposal that avoids the job-crushing Clinton and Congressional Democratic mistakes of employer mandates and payroll tax hikes. The Dole bill also avoids the stick of individual mandates, providing instead a carrot in the form of low income subsidies to induce people to buy insurance.

Nonetheless, there are mandates in the Dole bill that would dictate the design and the premiums of the policies that insurance companies could offer that will limit consumer choice and raise the cost of health insurance for most people.

The real issues of health care reform should be 1) how to assist the poor who cannot afford ordinary coverage or fees for preexisting conditions, and 2) how to fix the problems with the insurance market created by the tax bias in favor of employer-provided third-party-payor health care, such as lack of portability and over-consumption of medical services.

Throughout the entire debate on health care reform, Washington has consistently mis-identified the issue as 1) helping sick people, regardless of income, bear even less of the cost of their health care and insurance than they do now, and 2) of finding some mechanism for stopping the resulting rise in health care costs confronting the federal budget.

The Dole bill is no exception. While avoiding taxes and business mandates, it imposes insurance mandates similar to those imposed in all the other proposals with respect to pre-existing conditions, portability, and (modified) community rating. Furthermore, Dole's medical saving account proposal is ineffective and unworkable, and will do little or nothing to curb the over-consumption induced by over-generous employer-based plans.

Modified community rating is off-budget welfare for the sick, whether they need it or not. Forcing insurance companies to eliminate (community rating) or restrict (modified community rating) the risk differential in premiums for people of different ages or health status results in transfers from the young and/or healthy to the old and/or sick. If insurers have to give the under-charged high risk policyholders a partial free ride, they have to raise premiums above the actuarially correct amounts for their other policyholders. The latter, getting a bad deal, then tend to cancel their coverage, unless they are required by law to buy it.

Guaranteed renewal without a rate increase regardless of developing conditions is akin to forcing insurance companies to offer only multi-year policies at a fixed premium. Since the chances of getting a serious or chronic illness are higher over several years than over one, the average annual premium for such a policy must be higher than for single year policies with periodic rate adjustments for new conditions. In other words, people who formerly bore some of the cost of their illnesses through higher premiums in the years after they became ill will now be covered by the insurance, which means that premiums must be higher in all years for all members of the pool. People could have demanded such policies from insurers in the past, but they chose not to. Why should the government make them the only policies that can be sold?

The real issue with respect to preexisting conditions is not whether insurers will provide coverage for people with preexisting conditions but

whether people can afford to buy policies with actuarially correct premiums. People can get coverage for pre-existing conditions if they are willing to pay a premium reflecting the likely costs of their health care. They may have to change insurers to get it, but they can get it if they shop around. The "problem" is that they don't want to pay an actuarially fair price for the policy. They want to pay a premium that is the same as a healthy person's. In effect, they want healthy people to subsidize their higher costs.

Disallowance of preexisting condition restrictions (although not as blatant in the Dole bill as in some other proposals) also does violence to the incentive to buy insurance at any price. No one expects a casino to let us bet on 17 red after the roulette wheel has stopped spinning and the little silver ball had already dropped into the 17 slot. State lotteries don't sell tickets today for yesterday's drawing. Betting after the fact, however, is exactly what the exclusion of preexisting condition restrictions allows. Requiring insurance companies to issue policies on demand, with little or no waiting period, to people with preexisting conditions, allows people to walk into an insurance office after they get sick and demand coverage. People who have been paying actuarially correct premiums must pick up the tab for those who have not been contributing to the pool.

Why should healthy people subsidize sick people? Not everyone who is sick is poor. Not everyone who is healthy is rich. If illness or death of a breadwinner or natural disasters or lack of education or being blessed with quintuplets have made some people poor, then by all means let us give them a hand — either through government assistance (welfare, food stamps, supplemental security income, or even health care vouchers) or through private charity. It should not be done through random cross-subsidies effected by skewing the prices of insurance policies to make healthy people pay more than they should so that sick people can pay less. If sick people can afford to pay for their own treatment and to pay a higher premium for insurance to cover their known conditions, they should do so. They should not demand a hand-out from total strangers who may well be less able to bear the cost.

If government aid to the poor is needed, it should be given through an open and honest on-budget program, not by mandating insurance companies to operate inefficiently and requiring them to subsidize some of the covered population while penalizing others.

Experts on health insurance and cost containment all agree that the real problem with runaway costs is that people don't see the cost of their health care, and over-consume. The care is paid for by third parties — employer provided care, insurance companies, etc. Most of the health care proposals on the table make this problem worse by trying to hide even more of the cost from the patient. Cost containment will not be realized, short of rationing and price controls, without providing individuals with strong incentives to economize on their consumption of health care. This requires replacing the existing tax-shelter provisions with something that requires the individual to give up a dollar of other products and services for every dollar he or she spends on health care.

The solution, obviously, is to switch the tax break and the locus of the insurance policy over to the individual.

Dole gives the barest nod to individual-based insurance by including a medical savings account in his proposal. But Dole's medical savings account is unworkable. Hemmed in by Joint Tax Committee rulings on what is revenue neutral and what is not, Dole's MSA's incentive is miserly: a deduction for deposits that is useless to people too poor to owe tax, and no tax-free build-up. It gives the saver absolutely no incentive to restrain health care outlays. Under Dole's plan, only health care outlays receive the tax break. Outlays from the MSA for other goods and services are subject to tax and penalty. Consequently, the saver is in a use-it-on-health-care-or-lose-it situation, creating another damaging incentive to over-spend on medical care

in addition to that created by the current tax subsidy for employer-provided health insurance.

The only way that an MSA can encourage an individual to economize on health care spending is to force him or her to give up something of value for every dollar spent on health. Toward that goal, the MSA tax break should be designed as a blatant "bribe" — such as a deduction for contributions, or, better, a refundable tax credit for opening the account, and tax-free build-up — to encourage people to buy a high deductible catastrophic policy. To make the saver reluctant to spend the MSA balance on health care under the deductible, there must be an alternative tax exempt use for the money in the account. Any workable MSA must allow savers to use the funds for general spending, sooner or later, without penalty. At the very least, the saver should be able to roll his or her MSA over into an IRA after reaching IRA-withdrawal age (59-1/2) or after becoming eligible for Medicare (age 65). Ideally, money in an MSA that is used for non-health care spending would receive the same total exclusion from tax as that used for health care, and be available at any age (like the current standard deduction and personal exemption). Such an account would make the saver choose between a tax free dollar of health care and a tax free dollar of other spending.

With this approach, the accounts would be a real alternative to employer-based policies. Portability would be automatic. Individuals would be free to negotiate with insurers for appropriately priced policies covering the services the individuals want (including coverage of preexisting conditions, multi-year flat-rate premiums or guaranteed renewal features, policies with or without mental health or substance abuse provisions, etc.). The build-up of the MSA would permit some self-insurance to avoid some of the premium hikes associated with age and illness.

A bill to deal with the real issues of health insurance would take the following approach:

- The tax break for health insurance should be relocated to individuals rather than employers to ensure portability.

- The tax break should be a generous, refundable, flat tax credit available upon proof of insurance or the establishment of a workable medical savings account (better crafted than the majority of those in current bills). It should be: generous enough to give individuals an incentive to take the trouble to sign up, including those with somewhat higher premiums due to age or illness; refundable to cover people too poor to owe tax; flat, so that people will shop for economical plans that force them to be aware of at least some of the marginal cost of the care they utilize, and so as not to subsidize every additional unit of health care consumption.

- Aid — prompt and generous — should be provided for people whose illness-related risk premiums and/or low incomes place needed coverage and potentially effective treatments out of reach.

- State regulations — mandated benefits, community rating, etc. — preventing insurance companies from offering plans tailored to the needs of the population should be overruled.

These steps address the real issues. None of the plans under active consideration on Capitol Hill — certainly not the Clinton plan or the Clinton lite Democratic Congressional alternatives, nor the Rowland-Bilirakis bill nor the Dole bill — comes close to hitting the target. Rather, they spray deadly "friendly fire" at the health and lives of the whole nation.

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Note: Nothing written here is to be construed as necessarily reflecting the views of IRET or as an attempt to aid or hinder the passage of any bill before Congress.