The New Atlantis
A Journal of Technology & Society

Health Care 2008: A Political Primer

James C. Capretta

Especially in election years, it is worth stating the obvious: reforming health insurance arrangements in the United States will not be easy. This truth is sometimes lost in the heat of a spirited political campaign, and indeed, the two remaining contenders for the Democratic Party's presidential nomination as of this writing, Senators Barack Obama of Illinois and Hillary Clinton of New York, have each raised expectations among voters that they will deliver a sweeping health care overhaul soon after taking office in January 2009.

It is of course *conceivable* that their promises could come true; it might turn out that Congress could pass a major health-care reform package in 2009 or 2010. But there are important reasons why such plans have not been enacted to date, and these include not solely the interference of so-called "special interests" in politics, as Senators Obama and Clinton have suggested. Rearranging health insurance to cover all, or even some, of the uninsured is a tremendously complex undertaking, both politically and programmatically. That's true of reforms aimed at expanding government involvement in health care as well as those intended to encourage more intensive price competition and consumer choice.

This is not to suggest there is no constituency for reform. There clearly is, and it has been growing in recent years. Existing insurance arrangements have become more unstable, leading more and more Americans to ponder whether there might be a better way. And surely there *is* a better way to organize the provision of health insurance. But formulating and legislating a new approach will require a clear understanding of the forces destabilizing today's arrangements, as well as the reasons past reform efforts have failed to secure broad political support.

On the surface, it might appear that those who favor a government-run health care system are closer to victory than those in the market-based camp. Those who favor a stronger federal role in health care certainly seem more passionate and committed to the issue than their opponents, and the Democratic candidates for president plainly consider health care

---

James C. Capretta, *a* New Atlantis *contributing editor, is a fellow at the Ethics and Public Policy Center and author of the health care policy blog "Diagnosis." He is also a policy and research consultant for health industry clients.*

to be among "their" issues in 2008. But perceptions can be deceiving. As currently conceived, the large reform plans offered by both sides in the long-running political fight over the future of American health care probably could not pass in Congress, largely because they have flaws that would make them not only practically unworkable but also unacceptable to important and influential factions in Congress. And considered from this perspective of legislative plausibility, it is actually proponents of a market-based reform who are now closest to coalescing around a workable and politically practicable reform program, one that would initiate necessary but incremental change without needlessly disrupting arrangements for Americans generally satisfied with the health care they have today; and therefore one that could both make a significant difference and stand a real chance of making it through Congress.

The Debate Begins

To better understand the broad factions and forces driving today's debates over health care reform, it is necessary first to understand the political origins of those debates, and how the promises now routinely on candidates' lips first found their way there.

We might do best to begin that story in 1991. Senator John Heinz, a moderate Republican from Pennsylvania, died tragically in a plane crash, and the state's governor, Democrat Bob Casey, appointed Harris Wofford—a political novice and former associate of President Kennedy—to fill the Senate seat until a special election could be held later that year.

The conventional political wisdom was that Wofford, who had announced his intention to run as the Democratic candidate in the special election after getting the temporary appointment, would not be a U.S. Senator for long. Republican Richard Thornburgh, then United States Attorney General in President George H. W. Bush's administration and a former two-term Pennsylvania governor, jumped into the race to fill the remaining three years of Heinz's term. On paper, Thornburgh seemed to have everything going for him: high name recognition, previous success in state-wide office, exposure on the national stage, and the ability to attract campaign contributions in a way his little-known opponent could not.

But a funny thing happened on the way to the ballot box. A relatively-unknown political consultant by the name of James Carville saw an opening for his long-shot client Wofford. With the country still struggling to emerge from the 1990-91 recession, polling data showed rising voter concern with the security and affordability of health insurance. Corporations

were cutting costs to become more competitive in the emerging global economy, and that meant fewer jobs in manufacturing and middle management, particularly in the Rust Belt. Middle- and working-class families were waking up to the reality that if the economy remained sluggish they might lose not only their jobs but their health coverage as well. And it was more than just a theoretical concern: the number of uninsured Americans was rising rapidly, from 31 million in 1987 to more than 35 million in 1991. With health care costs also escalating quickly, families in Pennsylvania and elsewhere were wondering how they would manage if they needed to get care but had no insurance.

Wofford could see that health care was his ticket to the Senate. He relentlessly attacked Thornburgh and President Bush for being callous toward the plight of those without insurance and vowed to champion "universal coverage" in the Senate if he won. It didn't matter that neither Wofford nor anyone else involved in the campaign had much of any policy substance to say on the subject. Anxious voters gravitated to his message that the federal government had an obligation to secure coverage for everyone—no matter what. Thornburgh's somewhat delayed response—modest proposals to help small businesses and other steps to ease cost pressures slightly—was widely viewed as defensive and inadequate. Wofford, who at one point had been forty percentage points behind in the polls, sailed to an easy victory, beating Thornburgh by ten points.

The Wofford Senate campaign was a watershed moment in the health care policy debates in the United States. Thereafter, politicians from both parties felt the need to have either a reform plan of their own or at least detailed positions on various approaches offered by others. Suddenly, everyone wanted to talk about the problems in health care. Hearings were held, bills were introduced, policy conferences were convened. Health care and health insurance had risen to the top of the political agenda. They have remained there ever since.

The Nature of the Problem

In retrospect, the Wofford phenomenon should have been readily predictable. An explosion of concern about health care was really just a matter of time, given the pressures that were destabilizing health insurance coverage for growing segments of the population. Sooner or later, the number of Americans feeling insecure about their health coverage was going to reach a critical mass and push the issue into the political arena. Wofford was just lucky—the right politician in the right election at the right

time. But, as his example also showed, it is one thing to shine a light on a problem; it is quite another to know what to do about it. In this context, sensible public policy requires a basic understanding of what was leaving so many voters feeling vulnerable.

Consumers purchase insurance to protect themselves against possible financial risks. Homeowners buy insurance to help pay for the costs of repairs in the unlikely event they experience a fire or flood. Many breadwinners buy life insurance to provide income support for their families in case of premature death. Art collectors buy insurance to protect their investments against the risks of burglary or damage.

In the context of health care, insurance is desirable because medical treatment, particularly hospitalization, can be very expensive. Most households do not have the financial resources to pay out-of-pocket for, say, the costs of cancer treatment or the surgery and other care associated with repairing injuries from a traumatic car accident. Most people need health insurance to help them pay for these large expenses.

But to work well, health insurance, like other insurance products, needs to spread the costs of expensive claims among many policyholders who are at risk for such costs but do not experience them all at the same time. It should be self-evident that insurers will not lose money continuously. Over time, they will collect enough in premiums to cover their customers' claims, with enough left over for administrative costs and a profit. If there are large numbers of policyholders paying premiums to protect themselves against the risk of expensive health care but not submitting expensive claims, then the excess premiums they pay can be used to offset the costs of the much smaller number of other policyholders who do in fact need expensive health care.

Somewhat by accident, in the United States, it is employers who mainly provide the structure for pooling health insurance risk. During World War II, the Internal Revenue Service allowed businesses to offer tax-free health benefits to workers. (This was intended in part to make up for wage controls that the government had imposed; employers couldn't use higher wages to entice workers, so they offered health care benefits instead.) Insurers generally liked this approach to organizing coverage because it allowed them to capture large numbers of enrollees, in relatively stable risk pools, with a small number of group insurance sales. In most cases, there should be no reason to expect a business to have an atypical ratio of sick to healthy workers because hiring is not based on health status.

In a sense, the federal tax preference for job-based coverage has been a spectacular success. The vast majority of working-age Americans and

their dependents have private health insurance coverage—which, by the way, they generally like. As of 2006, more than 177 million Americans were enrolled in job-based health coverage, according to the Census Bureau. This insurance generally provides good financial protection and access to some of the finest medical institutions in the world. And the full and open-ended exemption of employer-paid premiums from both income and payroll taxes has unquestionably motivated large-scale enrollment. For a middle class family in the 25-percent federal income tax bracket, the exclusion of $12,000 in employer-paid premiums (about the average for family coverage today) is worth $4,800 in foregone tax liability, including the foregone payroll taxes at the 15.3 percent employer-employee rate.

But despite its many advantages, the employer-based insurance system is the Achilles' heel of American health care, for three reasons. First, the open-ended federal tax preference for employer-paid premiums is fueling cost escalation. Although employers arrange insurance pools, individual households really pay the premiums. The cost of enrolling in health insurance, even when "provided" by an employer, is effectively paid by workers in the form of lower cash income. As premiums have escalated more rapidly than pay over the last four decades, take-home pay has appeared stagnant, or even appeared to decline, because rising compensation levels have in many cases been more than matched by rising health care costs.

The Congressional Budget Office recently estimated that between 1975 and 2005 health care costs went up, on average, 2.2 percentage points faster every year than per capita GDP growth. That means, over many years, more and more of the typical household's disposable income has gone to health care premiums and out-of-pocket costs, squeezing out other priorities. According to the Employee Benefit Research Institute, the average premium for family coverage provided by employers went up 80 percent between 2000 and 2006, far outpacing the 15 percent increase in median household income.

Why are health care costs rising so fast? Many economists point to the role of third-party payments for services. With health insurance, a policyholder has much less reason to be sensitive to the prices he pays when receiving a service because the insurance is generally paying for most of the bill at that point. The typical cost-sharing obligation for a patient is perhaps 20 percent of the bill, sometimes much less, and the patient often does not even know what the total bill is.

This tendency is exacerbated by the tax treatment provided to employer-sponsored coverage. Today, the tax exemption has no upper limit. No matter how expensive the health insurance premium, if the employer is paying, it is tax-free to the worker. Employees thus have a strong incentive

to take more and more of their compensation in the form of health coverage instead of cash wages because the health coverage is not taxable. For every dollar spent on health coverage, you receive a full dollar of coverage; whereas with every dollar received in other forms of compensation a portion has to go to the government. This creates an incentive to spend more, which in turn offers insurance and health care providers an incentive to charge more. And this greater spending on insurance also leads to lower deductibles, so that the individual patient at the doctor's office pays less out of pocket, and therefore has a lesser sense of what things cost, further fueling the demand for more and better services—since patients enjoy the benefits of the services without directly feeling the pinch of their costs. Too many of the incentives, in other words, encourage higher costs, and too few encourage competition and cost containment.

The rapid spread of generous third-party insurance—both employer coverage for workers and Medicare for retirees—has for these reasons also coincided with the massive expansion of America's health care infrastructure. More technology-intensive hospitals, outpatient centers, and diagnostic facilities have sprung up in more communities in response to the ready availability of insurance payments. Of course, better health care facilities and enhanced capacity are mainly quite welcome developments, providing much greater access to a wide variety of services for Americans at all income levels. But they are also expensive. One recent study by an M.I.T. economist surmised that about half of the real health care spending increase that occurred in the post-war era up to 1990 can be attributed to the rapid spread of generous, third-party insurance arrangements, including employer-based coverage.

The second major problem with America's employer-based health insurance system is that the coverage isn't "portable"—it can't be moved from job to job. When an employer arranges insurance, it is owned by the business, not the workers. That means that when a worker quits a job or is laid off, he loses his health insurance too and must find some other coverage arrangement.

That's usually okay for someone going from one large business to another, because nearly all large companies offer good coverage. But many millions of workers, especially low-wage workers, often go from one small business to another, some of which offer coverage while others do not. According to a recent survey, 99 percent of firms with 200 or more workers offer health coverage, but only 60 percent of firms with less than 200 employees do so, and less than half of the companies with less than 10 workers offer health insurance. The problem is only compounded by

large numbers of seasonal and part-time workers, as well as the growing number of independent contractors who go from project to project and must arrange their own health and retirement benefits.

The result is unstable health insurance and frequent but temporary gaps in coverage for millions of people. News stories on the uninsured usually refer to the Census Bureau's estimate of the number of uninsured Americans, now at 47 million people as of 2006. But that statistic both overstates and understates the problem. Far fewer Americans are *permanently* uninsured, but many more experience *temporary* spells without coverage. A recent government study found that there were only 17 million people under age 65 who were uninsured for the entire period 2002 to 2005, but there were more than 80 million people who were uninsured for at least one month in either 2004 or 2005. Other studies have shown that "insurance churning"—the frequent, even monthly, switching between plans and from insured to uninsured status—is common.

Finally, the third problem with the American employer-based insurance system is that it stifles entrepreneurial initiative. The United States has one of the most flexible labor markets in the industrialized world, but it would be even more so if health benefits were not tied to the place of employment. More American workers would take risks and sign on with uncertain start-ups if they could secure health coverage through an arrangement that was not dependent on the financial viability of a risky business venture. But so long as federal law bestows exclusive health insurance tax benefits on employer-based groups, there won't be enough workers willing to look at other health insurance arrangements outside of the workplace to make them as affordable and stable as large employer plans.

ClintonCare

In Pennsylvania in 1991, voters were anxious and restless about the security of their health insurance because many of them were acquainted with others who had become uninsured, at least for a short spell. With costs rising and limited options for getting affordable insurance outside of work, voters were sensing their vulnerability and looking for help from their politicians.

Fresh from the Wofford victory, James Carville believed he could tap into the same sentiments around the country. He turned his considerable talents to electing another long-shot Democratic candidate, then-Governor Bill Clinton of Arkansas, who was running to unseat George H. W. Bush in the 1992 presidential race. Health care once again featured prominently

in the campaign. Clinton promised that, if elected, he would provide "universal coverage" for all Americans in an approach that would be neither fully public nor fully private. Few details were offered—but, once again, the specifics didn't matter. Clinton won the election (not only because of his health coverage promises, of course, but they certainly played a part) and assumed he had a mandate from the people to pursue a sweeping health care plan in Congress.

But Clinton badly overreached, and by late 1994, the country and the Congress had turned decisively against the notion of adopting fundamental changes in health care arrangements. In one year's time, support for the Clinton plan fell from over 70 percent to just 43 percent, according to Harvard professor Robert Blendon, a health policy analyst.

Why? For starters, the Clinton White House made a series of public-relations blunders. It was widely reported that then-First Lady Hillary Clinton and her top aides devised their plan behind closed doors in an effort to keep control over the details and limit input from the many members of Congress with strong points of view. That perceived arrogance, of course, was sufficient reason for many Representatives and Senators to oppose the program. The Clinton plan also envisioned an expansive new bureaucracy and expensive mandates on businesses, as well as massive *new* entitlement commitments at a time when many in Congress were just becoming aware of the huge impending (and unfunded) cost of the existing government entitlement programs.

The general sense in Washington and around the country was that "ClintonCare" was just too much government, but that was surely an oversimplification. The chief flaw of the Clinton plan was actually its approach to cost control. To "guarantee" health insurance for everyone, the Clinton plan would have created a new entitlement to subsidize coverage for the low-income uninsured. But such subsidies would only be affordable within the bounds of the federal budget if they increased annually at no more than the rate of national economic growth. If the costs escalated at the historical rate of health care inflation, they would push the federal deficit ever higher and require more borrowing and debt. Any government entitlement to health care would make rising health care costs a growing problem for government budgets; and so any such plan would require some measures to control these rising costs.

The Clintons professed to believe in "managed competition" in health care, but they failed to provide the mechanisms necessary to instill real price competition in their plan. Importantly, they flatly refused to limit or restructure the federal tax subsidy for employer-sponsored coverage

to encourage more cost-conscious consumption. This decision may have served them well in the short term, since powerful labor unions were adamantly opposed to any tampering with the tax-favored status of the expansive, collectively-bargained health plans they had secured over the years. But it left the Clintons with no choice but to impose heavy-handed government controls on costs—not that they needed any real convincing. It was readily apparent that the Clintons—especially First Lady Hillary Clinton—deeply distrusted markets in health care and were intent on pursuing European-style cost controls instead. Buried deep in the bill they presented to Congress was a provision to limit the annual growth rate in premiums that insurers could charge enrollees—so-called "premium caps." But the only way to enforce such caps is with price controls; the bill therefore extended to private insurers the authority to use government-set payment rates when paying hospitals, doctors, and other service providers. Thus the government would essentially set prices for private sector health insurance by fiat.

With so much authority turned over to the federal government to keep costs down, it was apparent to all that the Clinton plan would have led to a government takeover of American health care. In time, government price controls would lead, as they have in Europe and Canada, to reductions in the numbers of willing suppliers of services, which in turn would lead to waiting lists, deteriorating care, and rationing. In the final analysis, it was this threat of government control over health care provision that led millions of Americans to reject the Clinton effort as completely misguided.

The Clintons, of course, flatly denied that their plan would lead to the rationing of health care. But the public didn't believe them. Their plan never came up for a vote in either chamber of Congress.

A Conservative Vision

Fast-forward to 2008. Senators Clinton and Obama are running for president, both pledging to reform health care and provide health insurance to all Americans. What is their theory of cost control now? The language of Democratic health financing reform has changed somewhat since 1993, but the underlying theories have not.

Of course, neither Democratic candidate will admit that what they really want is government-enforced cost controls, because they know they would be attacked again—and accurately—for endorsing government rationing of care. Instead, they are trying to convince voters that costs can be controlled with a series of government investments in how health

care is delivered. They call for more government subsidies for investments in health information technology, for instance, and more government-sponsored studies of what works and what doesn't in actual clinical practice, or more attention to preventing chronic diseases, like diabetes. To be sure, all of these changes might help in some small way to improve the efficiency of health care delivery. But their effects would hardly make a dent in the larger picture of escalating health care costs, and it stands to reason that these new government "investments" will also grow burdened with waste and bureaucracy, as current ones have.

More fundamentally, none of these steps change the basic financial incentives at work in expansive third-party insurance. When it comes to cost control, therefore, today's Democratic candidates have not gone much further than Bill Clinton did in 1994. Without embracing market mechanisms to control costs, they are left with only one choice—government-enforced price controls—which voters will oppose again if they understand them as they did the last time around.

Back in 1994, Republicans put forward a series of bills to counter the Clinton plan. Much like the Thornburgh campaign's proposals in 1991, these bills would have pursued sensible steps to help small businesses get better coverage, reform medical malpractice laws, and invest in public health clinics. But the main focus of Republican members of Congress at that time was not on passing their own ideas but on exposing the flaws of the Clinton plan in order to defeat it. They were able to beat something with a minimalist plan by showing that Clinton's particular something was ill-conceived.

With that mission accomplished, however, conservatives soon realized that the issue was not going away. The fundamental pressures leading to unstable insurance had not been relieved, so the problem would only get worse with time. A real solution, not just a case against the Democrats' approach, was called for. If not the Clinton plan, then what?

Some of the brightest conservative economic minds went to work on the issue, including Mark Pauly from the University of Pennsylvania, Stuart Butler of the Heritage Foundation, and John Cogan from the Hoover Institution. What is most striking about their body of work is the consistent and adamant insistence that effective reform starts with changing the federal tax treatment of health insurance. There are, not surprisingly, some differences among the experts on the details. Some economists would prefer to convert the current tax preference into a refundable credit for households to use to purchase whatever kind of health insurance they select. Others would give taxpayers a uniform standard deduction to replace the exclusion provided to employer-paid premiums. Still others would prefer to leave the

current tax preference in place for employer plans, but limit the amount that is tax-free in any given year to discourage overly expensive premiums.

But such differences on the details are minor in comparison to the agreement among these analysts that nothing in health care will get fixed if the federal tax treatment of health insurance remains as it is today. Sensible reform of the tax treatment of health insurance would go a long way toward correcting the shortcomings of today's arrangements because more expensive insurance would no longer enjoy additional subsidization, forcing more cost-conscious purchasing by millions of households, and more cost-conscious insurance options from the industry. This is the essence of the new conservative health care agenda.

But agreement among academics does not necessarily translate into ready acceptance among politicians, particularly when what is on the table is profound reform of a long-standing practice in an area as sensitive as health insurance. Indeed, it has long been the conventional wisdom among the political class that reforming the tax treatment of employer-based health insurance may make sense as health *policy*, but the *politics* are horrendous at best. What could be more unpopular than suggesting a tax hike on fringe benefits in which the worker gets no additional take-home pay?

By 2007, however, it was becoming clear that the country was headed toward another debate on health care reform and the uninsured. The Democratic candidates for this year's presidential race were already signaling their intentions to raise the issue aggressively in the campaign to come. For conservatives, the moment of truth had arrived: To compete on health care issues, they had to put before the public the crucial concept of their vision of reform or risk ceding the issue entirely to those who favor a more heavy-handed governmental solution.

President Bush embraced the challenge. In his State of the Union address in January 2007, the president laid out a plan to convert the current tax preference for *employer-paid* insurance into one in which all *households*, including those buying insurance on their own, would get the same standard deduction ($7,500 for individuals and $15,000 for families).

Of course, the Bush proposal was not seriously considered by the Democratic-controlled Congress, but that was not the point. The president's proposal was crucially important because it paved the way for others to offer similar plans, including the emerging field of presidential candidates. And indeed in short order all of the major Republican candidates for president embraced tax reform as the centerpiece of their health care agenda, including the candidate who is now the presumptive nominee, Senator John McCain of Arizona.

Senator McCain favors converting the current tax preference for employer-paid coverage into a uniform, refundable tax credit. All Americans, whether working or not, would get the same amount ($2,500 for individuals and $5,000 for families) to use to offset the premiums for the insurance plan of their choice.

The boldness of the McCain proposal, and its potential for shifting the debate on health care reform, are hard to overstate. Unlike 1992, the Republican candidate for president in 2008 will have a credible proposal on the table to counter the one offered by his Democratic opponent. And indeed, McCain's proposal to transform the core of our health insurance financing system is far more aggressive than Hillary Clinton's or Barack Obama's plans. Moreover, Senator McCain's campaign will likely use this proposal to forcefully argue that only intensive market competition can slow cost escalation without harming access and quality—a contention that many respected experts will line up to support. The Democratic nominee, meanwhile, will likely be much more reticent about admitting that his or her plan is premised on centralized and bureaucratic cost-control mechanisms the public has rejected before. Properly explained and advocated, McCain's plan could profoundly alter the character of our health care debate, and begin to stake out a Republican claim in terrain that has long been abandoned to the Democrats.

The McCain Plan in Practice

Senator McCain has the stronger substantive argument on the question of how to contain health care costs most effectively. His proposal to convert the tax preference into a tax credit would turn millions of households into price-conscious consumers, with dramatic implications for price and quality competition among both insurers and those delivering health care services.

But precisely because it proposes such a bold reform, McCain's plan will also raise some serious questions of implementation and transition, which his opponent this fall will surely seek to press. To win the health care debate in the long run, conservatives will need to be able to give a clear answer to the question most Americans will surely ask: If the proposal were to pass, where would I take my federal tax credit to get health insurance? What, in practice, will the experience of getting health insurance under this new system involve?

Proponents of market-based health care would respond, of course, that supply would emerge to meet demand. With millions of households

newly freed to get insurance wherever they wanted, companies would move aggressively to make additional products available.

That, of course, is very likely true. Unfortunately, many Americans are at least vaguely familiar with the current individual insurance marketplace. While it works well for some, it is too idiosyncratic to provide confidence that stable choices are possible outside of the employer system. There is a general sense among Americans that the individual market is an unpleasant last resort, and the bumps and bruises that inevitably accompany a transition as significant as the one the McCain plan envisions would only reinforce this impression.

The problem is compounded by the differing premium structures which operate inside and outside of employer-based plans. In general, workers enrolled together in an employer plan all pay the same premium for coverage—this is called "community rating." So, a twenty-something worker and one near retirement in the same company both pay the same premium even though the near-retiree has much higher expected costs every year. In effect, in job-based health insurance, the young subsidize the old and the healthy subsidize the sick.

The same kind of subsidization does occur in the individual insurance marketplace, but it is much less pronounced. In most states, insurers are allowed to charge higher premiums for older enrollees as well as somewhat higher premiums for those who have experienced an expensive health episode in the past, so that (to cite one real example) a twenty-year-old might pay $92 per month while a sixty-year-old might pay $374 per month for similar coverage. With Senator McCain's tax credit reform, individuals may choose where to get their coverage. Absent other regulatory changes, that would seem to imply that younger, healthier workers now in employer-sponsored coverage would find it advantageous to buy their insurance on their own, outside of the workplace, in order to take advantage of the lesser subsidization of older enrollees in the individual market. Critics worry that this phenomenon—called "risk segmentation"—would unravel the entire employer-based structure.

Conservatives must answer these criticisms to succeed, but that will require making some difficult decisions about design and regulation. The most sensible option—the conservative approach to a conservative reform—would be to pursue Senator McCain's reform vision incrementally, so as not to unduly disrupt today's employer-based coverage. That would have the added advantage of not alienating millions of voters who may want to fix the system as a whole but are generally pleased with the coverage they get at work. To do this, Senator McCain would need to

limit initial eligibility to the tax credit to a more targeted population. For instance, he could make it available to anyone not attached to employment insurance and those working in firms with fewer than 51 workers. This approach would leave most workers in their employer-based plans, but would still launch a more vigorous marketplace for completely portable insurance for those outside of the larger employer setting. It would still be important in such a scenario to apply more of the discipline of the marketplace to health insurance. That could be accomplished by setting an upper limit on the amount of the tax exclusion for employer-paid premiums for those who remain in job-based coverage. For instance, the limit might be set at about $15,000 to $17,000 for family coverage, indexed only to price inflation. Over time, more and more of the expensive employer plans would cross these limits, forcing the businesses and workers involved to reevaluate the coverage and look for ways to economize.

Senator McCain should also give the states great latitude on the regulatory structure used to provide coverage for those eligible for the tax credit. Using such latitude, states should consider setting up an "insurance exchange," as Massachusetts did with its "Connector" in 2006. The Massachusetts plan, enacted as a compromise between the state legislature and then-Governor Mitt Romney, is controversial among conservatives, and for good reason. The law mandated the purchase of expensive insurance by every state resident. State regulators are limiting market participation by insurers under the plan, stifling competition and choice. And the plan does not foster strong price competition, thus making it unlikely to be sustained without significant tax increases.

But the Connector itself is well worth studying, and perhaps emulating elsewhere. It provides a central location for information about insurance options, as well as an administrative structure to facilitate the payment of premiums and subsidies to participating plans on behalf of enrollees. This is no small matter. States that have such exchanges could provide a ready answer to the question raised by Senator McCain's proposal: Where do I go with my tax credit?

Moreover, states run large Medicaid programs, and the McCain tax credit proposal would largely run parallel to these programs. With a Connector-like structure in place, states could begin to move their Medicaid population out of government-run insurance into a more competitive marketplace, thus beginning to offer not only an answer to the challenge of insurance stability and portability, but also some relief from the burden of existing health care entitlements.

The Next Conservative Issue

All of this suggests that for Republicans, just as for Democrats, much work remains to be done to turn general concepts into detailed policy proposals. But it is crucial to see just how much progress has been made since the first iteration of the health care debate, and just how much better positioned Republicans now are to take the initiative. In 1991, most conservatives were completely ill-prepared to engage in the health care debate that burst onto the national scene. Today, they are ready with an explanation of the problem, and with the outlines of a real solution. Their views on why health care costs are rising rapidly are intellectually coherent and point toward a decentralized market-based remedy that stands a better chance of working, and perhaps even of appealing to voters, than the Democrats' ideas. For fifteen years, health care has been the preeminent Democratic issue. Largely unchallenged, the Democrats have not felt the need to rethink their essential approach to the problem of escalating costs, and so have attached themselves to a remedy that can readily be shown to require more government heavy-handedness and more rationing and waiting than the American public is likely to be willing to stomach.

The Democrats are not yet alert to their growing vulnerability on health care, and the Republicans are not yet ready to make a full-throated pitch for their new approach. But there is nothing like an election season to focus the mind, and if John McCain can focus on the proposal he has already put on the table and can make a clear and concise case for its merits and for the deficiencies of the Democrats' idea, we may well be witness this year to the emergence of the next great conservative reform effort. Indeed, health care reform just might turn out to be what tax reform was in the 1980s and welfare reform was in the 1990s: a platform for a focused conservative effort to achieve through market forces and economic incentives what the left has failed to do through government.