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Prescription for Health Care Policy

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With health care delivery increasingly shaped by market and budgetary discipline, the provision of adequate health care for all seems an ever-more-distant goal. The forces making for that outcome are hard to mistake. First, hospitals face unprecedented financial stress arising from the cost constraints private and public payers have succeeded in enforcing, with the result that uncompensated care cross subsidies, which have acted as a safety net for the uninsured poor, have been put at risk. Second, the cross subsidies from the healthy to the sick in the individual and small-group insurance market – another safety net – have all but disappeared, and underwriting (the process of dividing the market into risk categories) has become so aggressive that it is destroying the market for health insurance for those not covered in a large-group plan at work or by Medicare or Medicaid. Third, Medicare and Medicaid themselves face significant new resource constraints; even now Medicaid provides for only half of the population below the federal poverty line. As for Medicare, the coming imbalance between the workforce and the beneficiary population points to cutbacks in real services and to increases in tax rates. Finally, employment-based health insurance has become much less common than it was only a few years ago. Large companies have been able to shed fringe benefits by outsourcing work that had been done in-house, and employers who have continued to offer health insurance as part of a compensation package have passed on more of the cost to employees directly. The temptation for employees to drop coverage and become a "free rider" in the event of a major illness has risen accordingly, notably among the poorly paid, whose inflation-adjusted compensation has slipped in absolute as well as relative terms.

Dx: A Financing Scheme Wrong from the Start

Private hospitals succeeded in developing profitable outpatient treatment when Medicare and Medicaid shifted in the early 1980s from retrospective payments (which are based on actual costs) to prospective payments (which are keyed to diagnoses upon admission). Thus, they were in a position to cope with the revenue squeeze brought on by the new rules and with the resulting excess capacity, as they then had the market power to pass on unreimbursed costs to private payers. But with private payers driving an even harder bargain than Medicare and Medicaid, private hospitals are in danger of losing their role as agents of redistribution. And public hospitals are in no position to cope with the pending cuts in Medicaid baseline budgets. Harder cases, but not the resources to treat them, have been shunted their way by revenue-squeezed private hospitals.

Americans have been willing to tolerate the rationing of medical care by price in the belief that the rationing breaks down in the event of real need (Brown 1990), but all too often that is not the case. The number of people denied access to health care reflects the growing impoverishment of those at the bottom. The uninsured population falls broadly into three groups (Wilensky 1987):

- The employed, who with their dependents account for about 75 percent of the total. They tend to earn low wages and to work for relatively small firms, particularly in service industries. Turnover is high.

Even bare-bones insurance would be as much as one-quarter of the total compensation of a worker whose wage is at or just above the federal minimum.

- The medically uninsurable, who account for no more than 2 percent of the total. They cannot obtain affordable insurance because of preexisting conditions. Many states have formed high-risk insurance pools, which are highly subsidized, but the appeal of the federal portability legislation, which addresses the problem supposedly taken care of by states' high-risk pools, testifies to the states' failure to solve the problem.
- The nonworking indigent, who account for the remainder. These are the long-term jobless and the chronically ill – many of them deinstitutionalized mentally ill, substance abusers, or homeless. They fit the Medicaid model, but they fail to fit into one of the eligible categories (e.g., an AFDC recipient) or they have an income above the cutoff level set in many states.

The high cost of American health care (relative to the past and to other industrial countries) is the inevitable by-product of its method of financing – subsidies to care through the tax exclusion of insurance premiums. Moral hazard – the tendency for insurance to increase the likelihood that the insured-against event will occur – is a threat to a well-functioning insurance market under the best of circumstances (Hall 1994). Generally, insurance buys two services: protection against the financial consequences of a major unforeseen illness (a reasonable use of insurance to spread risk) and prepayment for routine and thoroughly predictable expenses that otherwise would have to be paid out of after-tax income (an unreasonable use of insurance made reasonable only by the tax exclusion). The prepayment is not insurance, but a form of tax-free compensation. Tax exclusion therefore leads to more health insurance for employees than they otherwise would have.

Tax exclusion also violates canons of tax equity. Because tax benefits rise with the employee's tax bracket, the comprehensiveness of the insurance plan, and the share paid by the employer, the exclusion acts against the principle of vertical tax equity and makes the subsidy especially generous to high-income employees – the very people for whom insurance with high co-payments (a sure way to limit moral hazard) is particularly appropriate. For example, for employees earning \$100,000 to \$200,000 per year, the average tax subsidy is about \$2,000, as much as the average cost of health insurance for families with \$10,000 in wages (Congressional Budget Office 1994).

Medical savings accounts and so-called flexcomp accounts, which permit employees to make co-payments and pay for noncovered health-related items out of before-tax income extend the arena of moral hazard still further. They also violate canons of tax equity.

Business often voices concern that the nation's competitiveness suffers as a result of high health care costs. However, health insurance is but one aspect of labor costs. Moreover, countries with whom the United States competes internationally typically have significantly higher fringe benefits. The real issue is alternative uses of resources; a rise in health care expenditures faster than in expenditures as a whole "crowds out" other expenditures – whether for education, other investment, remedy for the nation's social dysfunction, or any other purpose. Having lower expenditures for health care would not help the United States compete more effectively in international trade; it would, however, make for better use of national resources.

The problem with insurance from a social point of view, it should be acknowledged, is its virtue from an individual point of view. Insurance allows sick people to make decisions about treatment with little, if any, regard for cost – no small gift at a time of trouble. But insurance, especially if it is excessive as a by-product of tax subsidies, reduces the incentive people otherwise would have to seek out efficient providers of care and to monitor the care they are given. Market forces – which cannot work all that well in health care in any case – become weaker still.¹ The effect of tax-favored medical insurance is to spur new types of treatment that may be better than the ones they replace, but also considerably more costly.

Rx: An Individual Mandate and a Tax-Credit Subsidy to Fund Universal Care

A reasonable alternative to the current health care system is to require people to obtain health insurance as individuals (rather than employees) out of after-tax income and to subsidize that insurance as necessary. The subsidy could be financed by ending the exclusion.

A requirement that people carry health insurance may seem burdensome. It is no more so, however, than the requirement that all car owners carry liability insurance because an uninsured driver represents an unfair potential cost to everyone else on the road. A mandate is not all that onerous if it is accompanied, as needed, by the financial resources to pay for it. A mandate, moreover, is less of a constraint on free choice than it would have been in an earlier time when employees had greater choice of medical insurance than they have now in the era of the HMO.

A Basic Tax-Credit Plan

Taxpayers would qualify for a credit against their income tax for all or part of the cost of health insurance that either their employers had paid on their behalf or they had paid directly. Nontaxpayers (most of them presumably in the lowest income brackets) would have designated state or local government agencies pay the credit directly to the insurance carriers. The object of the credit would be to fund basic, comprehensive health care that families could not pay for themselves without risk of catastrophic financial loss. At relatively low income levels, no deductibles or other co-payments would be required; the credit would be adequate to cover the full cost of the basic plan. As income rises, the credit would fall below the cost of the plan; the rest of whatever health insurance the insured obtain plus any deductibles and other co-payments would be paid for out of after-tax income. As income rises further, the credit would fall to zero; all health insurance costs plus co-payments would come from after-tax income.

Evidence of insurance coverage would have to be supplied to the IRS, either by taxpayers (employees could use a W-4 form) or by the state or local agencies acting on behalf of nontaxpayers. Taxpayers failing to provide such evidence would be enrolled in a fallback insurance plan to be funded by surtaxes levied on those taxpayers. The federal government would select fallback plans by competitive bidding in each geographical market area – a way not only of enforcing universal coverage, but also of goading the health insurance market back to the principle of community rating.

One option for the design of the basic plan would be to base it on any relatively low-cost plan that had already captured a sizable market share. The dollar amount of the full credit would vary with subscriber age, family size, region of the country, and perhaps a few other broad categories, but only a few in order to push the insurance market away from risk rating. Another approach would be to draw on the experience of states that have given serious thought to the kind of services government ought to provide when state funds are used to pay medical bills. Existing Medicaid coverage could also be the basis for the design of a basic federal plan.

An individual mandate and replacement of the exclusion with a credit scaled to income are the key features of a plan put forth several years ago by Mark Pauly and his associates – a plan designed to achieve universal coverage and at the same time build in incentives to contain costs (Pauly, Danzon, Feldstein, and Hoff 1993).² According to that plan, families with income at or near poverty levels would qualify for a credit of 100 percent to finance a basic, although comprehensive, health plan; the credit would be reduced progressively with income, reaching zero at, say, four or five times the federal poverty level.

The Congressional Budget Office has designed an illustrative tax credit that would replace the 1994 tax exclusion in a revenue-neutral way. The credit would equal 100 percent of premiums of \$1,775 for single returns, \$4,425 for joint returns, and \$3,750 for head-of-household returns for those with income below the threshold for filing income taxes. It would be phased out for incomes between one and three times the threshold: \$6,250 to \$18,750 for single returns, \$16,150 to \$48,450 for joint returns, and \$12,950 to \$38,850 for head-of-household returns.³ A family with adjusted gross income of, for example, \$25,000 in 1994 would qualify for a 73 percent credit on premiums up to \$4,425 (Congressional Budget Office 1994).

Ending the tax exclusion (especially if lost state tax proceeds were added in) would yield revenues adequate to provide the needy uninsured with basic, comprehensive coverage and to offer some subsidization well into the middle-income range. There would be ample scope for both in the \$74 billion of forgone federal income and payroll taxes the exclusion represented in 1994, the \$5 billion of revenue lost that year to state treasuries, and the \$11 billion that Washington disburses to hospitals annually to assist them in the payment of uncompensated care and on matching funds and similar support from state treasuries.⁴ With universal

coverage, such assistance would no longer be necessary.

The federal government's role would be to ensure that plans funded by the tax credit meet minimal standards of protection for subscribers and to channel high-risk subscribers to insurance pools, subsidizing the higher cost as necessary. Significantly, a standards role for the federal government would preempt state laws mandating inclusion of specific medical services in insurance plans.

There are a number of issues that would have to be resolved in implementing any tax-credit plan. A plan that gears tax subsidies to need and is revenue-neutral would have to decide on the size of the tax credit that would apply at the lowest income levels, the services that would be covered under a basic plan, and the size of the subsidy appropriate at other income levels. The plan would have to resolve a range of administrative issues, such as what counts as income and what does not, what penalties should be imposed to enforce the individual mandate, and how credits are to be disbursed during the year to households not covered by health insurance at work and unable to make up-front premium payments. However complex, all of these are issues with which the tax system has had to wrestle in the past.

Consequences of the Basic Plan

Ending the tax exclusion and replacing it with an income-scaled voucher would improve the operation of the health insurance market, would result in a more efficient labor market, and would reduce overall health care costs. In so doing, it would have major implications for health care delivery. Such a credit would end at a stroke the horizontal and the vertical inequity in the tax exclusion.

Without the exclusion to make it reasonable to use insurance premiums to pay routine and predictable expenses and with the tax credit capped at the cost of the basic plan, Americans would seek less expensive insurance and push the market toward catastrophic coverage featuring high deductibles and other co-payments. These changes would curtail claims processing and other administrative costs, thereby reducing moral hazard and, in turn, the pressure on costs. With such a change, health insurance would come to be viewed not as an entitlement linked to a job, but as real insurance. The ad hoc subsidies now flowing through hospital bills (which are ultimately paid for by society at large) would be made explicit and transparent. There would be better balance between routine and emergency care. Requiring all to be insured would remedy the problem of adverse selection (the tendency of those with low risks to self-insure and those with high risks to overinsure), causing each insurer to expect "a random slice of all risks," with "no need to charge a premium higher than the average expected for a given risk class" (Pauly, Danzon, Feldstein, and Hoff 1993). A mandate alone would not make health insurance affordable for the working poor, but it would undo the breakdown of the individual and small-group insurance market that has prevented others from obtaining affordable coverage.

The suggested changes also would improve the overall efficiency of the labor market since the tax rates of the salaried and the self-employed would be on the same footing, the discrimination that keeps people out of a job because their potential employer's health care costs might soar would be ended, and decisions to retire before age 65 would not be so affected by health insurance considerations.

Some incentive would remain for employers to continue to play a major role in health insurance. Employers are uniquely qualified to process information about insurance contracts on behalf of their employees; group health insurance is apt to continue to be significantly cheaper than individual insurance; and employers are naturals at pooling risk and thus at fostering community rating in the insurance market. Alternatively, unions, trade and professional associations, other nonprofit organizations, or government itself would have to assume a larger sponsorship role or new sponsors (churches, civic organizations, or other community groups) would have to emerge.⁵

How health care expenditures would be affected by replacing the tax exclusion with a credit is hard to judge. The RAND experiment suggests that the trend to higher co-payments would give rise to significant economies, albeit at the cost of some forgone preventive health care (Newhouse and The Insurance Experiment Group 1993). Those savings could well offset much, if not all, of the additional cost of going to a universal system, especially since universality itself would yield economies in the early detection and treatment of disease. One study found savings as high as one-third of the medical care spending that is driven by employment-based

insurance (Phelps 1996). While other such studies have been less optimistic, they nevertheless have found savings in the range of 10 percent to 20 percent for private sector health care expenditures and about half of that range for the system as a whole (Glied 1994). The savings would be even larger if viewed in the broader context of a more efficient labor market.

Increased oversight by consumers of the costs of their medical care, others claim, would do little to curb costs because these are so dominated by life-and-death considerations. Their judgment is that high co-payments would have minimal effect since almost one-third of the nation's health care spending goes to only 1 percent of the population in a given year; almost three-quarters of the spending goes to only 10 percent. These percentages underscore the extent to which health care in this country devotes resources to the difficult cases, often at life's end. A better tax system would change the benefit-cost ratios for a wide range of medical interventions and would avoid the waste of using insurance claims to pay for routine care. But no matter how sound the tax treatment of medical care costs, ethical questions about the scope of care (which go to the community's as well as the individual's claim on scarce resources) will remain.

Alternative Approaches

Universality could be achieved through a variety of means other than a tax credit. The Clinton administration's "pay-or-play" plan is regressive because it effectively compels low-wage employees to dedicate a disproportionate share of their income to health care. It also encourages employers to manipulate the system, for example, by switching from full-time to part-time workers. The plan further institutionalizes employment-based health insurance and therefore would have to be supplemented with cumbersome programs to extend health insurance to nonemployees and part-time workers.

All-payer systems like the Canadian model are said to be administratively simple and thus to channel more of the health care dollar to patient care. Controlling moral hazard shows up in the cost of claims administration in the U.S. system, but not in its Canadian counterpart, where it is embodied in the cost of budgeting. Moreover, budget constraints on local Canadian hospitals often result in long delays for surgical procedures, and limits on physician fees mean several short visits for patients with illnesses more efficiently treated in one visit. The empirical evidence indicates that overhead costs (adjusted to include some of the larger hidden costs) in the Canadian system are higher than under private insurance in the United States (Danzon 1993). Even with no difference in overhead costs, the Canadian model would be hard to replicate in the United States. Shifting to the public sector the 8 percent out of the total of 14 percent of GDP that private health care represents is the biggest problem in a country wary of government.

Integrating Medicaid and Medicare into a Tax-Credit Plan

Medicaid buy-ins (which allow those not quite poor enough to qualify for Medicaid to buy into the plan) would resurrect Medicaid's original design for the inclusion of all low-income households in medical care plans and would be scaled to income, which would limit their budgetary consequences. Those consequences nevertheless would be sizable, given the low incomes of most of the uninsured. Buy-ins, moreover, would extend a program that increasingly is identified with heavy-handed regulation, red tape, and stigmatizing of the poor and would leave employment-based health insurance intact. Grafting health insurance tax credits onto Medicaid rather than enlarging Medicaid itself has the advantage of eliminating the disincentive to finding a job that fear of losing their health care now gives to Medicaid recipients.

Medicare also could be brought into a credit arrangement. A heavily subsidized plan blind to income for all over the age of 64 may have made sense in the mid 1960s, but the approach needs reexamination in light of vastly changed circumstances. Subsidization has become deeper over the years as beneficiaries have come to pay a smaller share of overall Medicare costs. Integrating parts A and B of Medicare – with premiums and taxing of vouchers keyed to beneficiaries' income – would take a step in the direction of the principle of ability to pay and would allow moving to a voucher or premium-support system, both paralleling the design of the tax credit.

Integrating the public programs into a tax-credit plan, or putting them on a comparable footing based on ability to pay, would also give the nation an effective mechanism for governing the volume of subsidies to health care.

That, in turn, would act as a needed brake on the share of GDP dedicated to health care on the eve of the aging of the postwar baby boom.

Building a Constituency

Although health care reform of any size and scope is off the policy agenda for now, it is apt to resurface as a major national issue in the next few years. The next time round, replacing the tax exclusion with a tax credit may well get a serious hearing. Building a constituency for such a plan will not be easy, but it is possible. The point to be stressed is that individual-based health insurance cuts the increasingly tenuous link between health care and employment. It ties the health care security of most middle-income Americans to the welfare of the uninsured poor and thus makes universal care not just an act of benevolence but one of self-interest. Moreover, those who would benefit from a credit, net of a lost tax exclusion, would extend well into the middle-income groups (Congressional Budget Office 1994; Pauly, Danzon, Feldstein, and Hoff 1993). Even many high-income people would benefit from being able to pocket 100 percent of the difference in price between one plan and another, rather than 100 percent minus their marginal tax rates. And, like everyone else, they would profit from the control of health care costs apt to come about from the purchase of cost-efficient insurance.

The benefits for relatively high-income Americans would have to be seen – and sold politically – in a broader context, found in the virtues of a universal system: an end to cost shifting (a hidden tax but a tax all the same), relief from the squeeze on hospital revenue that threatens the quality of health care for even those of unlimited means, and a clear conscience that people in need really are cared for.

Corporate America could well form part of the constituency. Although it has benefited from the leveraging of compensation costs made possible by the exclusion, it is not well served by the damage to morale and to employee relations that has resulted when employees feel they have been denied needed care for themselves or a member of their family. Retaining a role in health insurance, even if only as sponsor, would foster employee welfare and end the hopelessly ambivalent position corporations now find themselves in as administrators of health insurance.

Other parts of the constituency could be formed around a phase-in of an income-scaled tax credit, funded by a gradual reduction of the tax exclusion or a cap on the exclusion above the estimated cost of the basic plan. Phase-in could start, for example, by including all children – an approach that would appeal both to the right's concern for "family values" and the left's concern for care of the poor.

It must be acknowledged from the start that a tax credit or any other means of financing universal health care involves a redistribution of income. The case for it can be made on grounds of efficiency and tax fairness. But the case would be more convincing if the political establishment were willing to present access to health care as a basic human right. That may be a novel approach in the context of a political debate that rarely seems to rise above appeals to narrow self-interest, but it might well fall on receptive ears if it were put forth in a clear voice.

Notes

¹ Stephen Felsted, chief financial officer of the Holy Cross Health System, makes this observation about one of Holy Cross's hospitals in Anderson, Indiana, where General Motors is a major employer: "Historically, we have experienced a hospital utilization rate of 470 acute admissions per 1,000 people in GM's capitated HMO plan for UAW members – more than double the rate for the exact same plan offered to state employees in the very same market. This is because GM cannot build co-payments into the premium design structure; the UAW contract specifically prohibits GM employees from picking up any of the cost of insurance" (personal communication 1996).

² The Heritage Foundation has put forth a similar plan (Butler 1992). It differs most importantly from the Pauly plan in having the tax credit open-ended, keyed to the actual health care spending of an individual or a family, instead of capped at a specific dollar figure. The Heritage plan was incorporated in the Nickle-Stearns bill considered in the 1993 congressional session, and it was the basis for the health care proposals put forth by President Bush in the 1992 presidential campaign. C. Eugene Steuerle (1993) of The Urban Institute is yet another leading advocate for replacing the tax exclusion with a credit.

³ One criticism of a credit that starts high and ends low is that it involves high progressive taxation over the income range of the phase-out. That is true enough. But that is a problem of every means-tested program; it lies in the very nature of subsidies pinpointed to need.

⁴ Telephone conversation with John Sheils of The Lewin Group, June 12, 1996.

⁵ Conversation with Robert E. Moffit of the Heritage Foundation, February 23, 1996.

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