Public Policy Brief

Prescription for Health Care Policy

The Case for Retargeting Tax Subsidies to Health Care

Walter M. Cadette

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Preface

Since the defeat in Congress of President Clinton's 1993 health care initiative, health care has ceased to be a "front burner" issue despite the fact that most of the problems related to access, type, and quality of care that existed then have worsened. More of the working poor and their families have no access to care, and those who do have health benefits are faced with increasingly restrictive limits on the type of services they receive. These problems, in conjunction with cost constraints, raise questions about quality of care. The breadth and complexity of the issue point to one possible reason why President Clinton's proposal failed to pass Congress, namely, that in attempting to deal with all of the problems of the U.S. health care system, the plan introduced as many new difficulties as it tried to resolve. And possibly for the same reason, health care issues have since been addressed on a more piecemeal basis, and primarily at the state and local rather than the federal level. Moreover, the direction that health care is currently taking, that is, toward managed care, does not address the problem of access to care for the 40 million Americans who are uninsured, nearly a quarter of whom are children.

Rising costs and budget pressures are at the heart of the problem of access to health care. As Senior Fellow Walter M. Cadette notes, hospitals have increasingly had to deal with cost constraints, putting their care of the uninsured poor at risk. Outsourcing and the use of contingent labor have resulted in a reduction in employment-based health coverage. If individuals who are not working or are not eligible for work-based insurance try to obtain coverage on their own, many (especially those with a record of illness) are not able to afford the high premiums resulting from aggressive underwriting practices. Medicaid, thought by many to be the ultimate safety net, currently provides for only half of those under the federal poverty line and, in this time of preoccupation with federal budget balancing, provides even less health care for the

poor than it did a year ago. Shifting demographics point to the possibility of a cut in services (or a rise in beneficiary costs) in the Medicare program, previously thought to be a politically sacred cow.

The proposal contained in this brief for financing health care—eliminating the current system of employment-based tax-exempt health insurance premiums in favor of the required purchase of a package of basic services with sliding scale deductibility—addresses the problems of both access and cost. The proposal for retargeting tax subsidies would be more equitable than the current system, would result in a better balance between emergency and primary care services, would eliminate the disincentives to work associated with the Medicaid program, and would be administratively more efficient. Moreover, any remaining subsidies, such as to hospitals, would be explicit and no longer be hidden in the cost of services.

To enact such a sweeping proposal would require political will and instructional effort. Educating the public about the plan's savings and distributional effects would be difficult, but essential. It would be necessary to provide a cogent explanation of how the current health care system is funded (for example, the existence and workings of cross subsidies and unfunded subsidies), how these subsidies will change under the new system, how the plan will affect the Medicare and Medicaid programs, and how the change from tax-free employment-based insurance will work. This brief provides a foundation for debate about reforming the health care system and could serve as first step in an educational campaign.

Dimitri B. Papadimitriou
Executive Director
April 1997

The Case for Retargeting Tax Subsidies to Health Care

Major change in American health care was inevitable in the 1990s (with or without the Clinton administration's ill-fated plan), but few anticipated how sweeping the change was to be. The spread of managed care has brought market discipline, however crude and imperfect, into the picture as never before. And the budgetary discipline imposed on Medicare and Medicaid in the 1980s has intensified.

Prospects for controlling health care costs are more promising than they have been in some time. Indeed, the rise in those costs has slowed dramatically in recent years; it could easily come into line with the rise in economic activity at large in the next few years. However, prospects for universal coverage have been set back. With health care delivery increasingly shaped by market and budgetary discipline, the provision of adequate health care for the poor—the lack of which has for some time been the major shortcoming of the American system—seems to be 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. Uncompensated care cross subsidies, which have acted as a safety net for the uninsured poor, have been put at risk as a result.

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. People with a history of illness and in need of recourse to that market are at risk of being screened out directly or offered unaffordable insurance made useless by the fine print. 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 face significant new resource constraints. To be sure, these programs must figure prominently in the broader fiscal retrenchment if the federal deficit is to be controlled. They account, after all, for 20 percent of the budget and for an even larger 28 percent of its growth in the past 10 years. Even now, however, Medicaid provides for only half of the population below the federal poverty line. The debate this past year over Medicaid's remaining a federal entitlement has obscured the more important point that, under either the Clinton administration's plan or the Republican Congress's plan, Medicaid will finance even less of the health care for the poor than it does now.[1] As for Medicare, the coming imbalance between the workforce and the beneficiary population as the post-World War II baby boom ages points to cutbacks in real services and to increases in tax rates. These will be all the larger the longer they are put off.

Finally, employment-based health insurance has become much less commonplace than it was only a few years ago. By outsourcing work that had been done in-house, large companies have been able to shed fringe benefits, which can run quite high as a share of total compensation for low-wage workers. 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. Strikingly, only 80 percent of Americans not covered under Medicare and Medicaid have health insurance, down more than 10 percentage points from the early 1980s. Health care, like many other aspects of American life, reflects the growing impoverishment of those at the bottom.

All of this bodes ill for the health care of the growing number of Americans who cannot afford to pay for their own care. And it bodes ill for the nation as a whole. It promises to make health care all the more rationed by price, all the less a basic citizenship right as it is in just about every other advanced country of the world. At the very least, Americans will find it increasingly difficult to square such a form of rationing with their view of themselves as a caring people.

The portability legislation signed by President Clinton last year protects some workers who because of preexisting conditions would lose their health insurance if they were to change jobs. But it does not address the broader and deeper problem of access to health care for the vast majority of the 40.6 million uninsured (Bennefield 1996) who are locked out by reason of income. If that is to be addressed seriously, the nation must rethink how health care is financed. In particular, hard questions have to be raised about the reasonableness of the subsidies coming through the tax exclusion of employment-based health insurance—subsidies that now cost federal and state treasuries more than $80 billion annually.

Tax exclusion of employment-based health insurance encourages those who can take advantage of it to make excessive claims on health care resources. And that is one of the main reasons why American medical care has become so costly and why, as a result, so many other Americans lack health insurance. The question of who pays becomes all the harder to answer politically when the bill is high. To the extent medical care is subsidized, it ought to be subsidized on the basis of real need. The nation would be far better off if health care policy (including Medicare), just as other aspects of public life, were governed by that principle.

Retargeting tax subsidies to fund medical care for all those in need of subsidy will not be easy to effect politically. The right has been unwilling to act like authentic conservatives and use the power of government to remedy problems the market cannot; the left has been wedded to an entitlement state that, in practice, has deprived government of the resources needed to deal with problems of poverty.

The need for fundamental reform of the nation's health care system will not go away, however (Aaron 1996). Indeed, it will become more pressing as the market and budgetary disciplines now taking hold bite even harder on a system that already has lost much of its institutional capacity to care for the low-income sick. And it will become more pressing as employment-based health insurance becomes even less the norm in changing labor markets. What is more, the financial stress hospitals face will adversely affect the health care of even high-income Americans who can afford the best care. Quality for all can be expected to slip in a regime of forced economies, just as public services have in the high-rent districts of such cities as Washington, D.C., and Newark, New Jersey. Those neighborhoods have not been immune from the broader forces

affecting the cities of which they are a part. Teaching, research, and other public goods are also at risk.

This paper lays out the case for fundamental change in the way the nation finances health care. The first section, a diagnosis if you will, is a look at how the tax exclusion of employment-based health insurance has driven up health care costs and, as a result, has made it more difficult to get closer to universal coverage. The second section, a prescription, outlines the structure of an income-based, universal tax-credit system. The third section considers the challenge of forging a constituency for such a plan.

Dx: A Financing Scheme Wrong from the Start

Employment-based health insurance was an accident of history. It took root in the 1930s when hospitals, hard hit by the Great Depression, formed Blue Cross plans to secure their revenues by having people in effect prepay their hospital bills. But it was not until World War II that Blue Cross came broadly into the workplace and health insurance covered a large part of the population. Employers found health insurance—which was exempt from wartime wage controls—an efficient and perfectly legal way of recruiting skilled workers in unprecedentedly tight labor markets.

Further impetus to an employment-based system came in the early 1950s when the IRS ruled that health insurance paid by employers was not taxable to employees. The IRS judged that it was hard to price the benefits any given employee received in a group plan and thus hard to estimate the income on which tax would be due. Moreover, the amounts at issue were relatively small—too small, in any case, to raise broader fiscal issues. The ruling was especially important as it coincided with the development of income taxation at relatively high marginal rates of middle-income groups, which until the war had been virtually exempt. By the early 1960s some 75 percent of the workforce was protected by employment-based health insurance, as compared with only 10 percent just before the war.

The system left out the old, the unemployed, and, more generally, the poor, who, when they did get medical care, relied on the charity of physicians and the cross subsidies coming through hospital billing.

Medicare and Medicaid were designed to fill that gap, and in the mid 1960s the nation was well on its way to fashioning a universal health care system. The system, it was thought at the time, may have been different in design from the systems of other industrial countries, where universal care was financed almost entirely by payroll or other taxes, but it was similar in function. The theory was that an ever-larger share of the workforce would be protected by health insurance at the workplace and that most others—important among them the 65-and-over population, which, unlike today, was disproportionately poor in the 1960s—would have their medical care financed by the new public programs.

The Uninsured

The vision of a universal health care system based on employment and on entitlements for those without a job faded, however, as costs surged in the 1970s and 1980s. Rapidly rising costs prompted for-profit insurance companies to become adept at shunning potentially high-cost subscribers and at selecting "good" (i.e., low) risks. Even Blue Cross was forced in many states by the competitive challenge of risk rating to abandon the principle of community rating on which it was founded.

The high cost of underwriting, in turn, pushed premiums in the individual and small-group insurance market to prohibitive levels, prompting many in that market to drop coverage, the tax exclusion notwithstanding in the case of small companies. Strikingly, administrative costs in the individual and small-group insurance market today exceed 40 percent. To be sure, the group-insurance model has been maintained for large companies (98 percent of employers with 100 or more employees offered health insurance in 1991, as compared with only 27 percent of employers with fewer than 10 employees) (Sullivan, Miller, and Johnson 1992 as cited in Hall). But, through outsourcing, even large companies have retreated from earlier commitments.

Rising medical costs, moreover, caused state governments (which have wide latitude in setting eligibility policies for Medicaid) to keep down the number of people who qualify for Medicaid on income grounds and to restrict the services provided to those who do qualify. Many states have followed a strategy of not raising the maximum income levels for eligibility (and thus of reducing the real income levels through inflation)—a key reason why nationwide only about 50 percent of Americans

who fall below officially measured poverty levels are enrolled in Medicaid. Even so, with medical care costs rising rapidly over the years, Medicaid accounted in 1994 for 17 percent of state and local government budgets, up from 10 percent just 10 years ago.

Not surprisingly, the uninsured population reflects these trends. It 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 (the minimum wage or just above for many) and to work for relatively small firms, particularly in service industries. Turnover is high (one of the main reasons their employers cite for not offering health insurance). But the more fundamental problem is that even bare-bones insurance—priced at, say, $2,500 a year for a family—would be as much as one-quarter of the total compensation of a worker whose wage is at or just above the federal minimum. With health insurance especially costly in the small-group market, the employer's choice all too often is to forgo it. Many employees would also forgo it (and take the equivalent cash income instead) if, in fact, they had a choice.

- *The medically uninsurable, who account for no more than 2 percent of the total.* They cannot obtain affordable insurance because of preexisting conditions, even as employees of Fortune 500 companies. 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—as it was conceived in the mid 1960s in any case—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 (especially relatively low-income) states.

The uninsured, it is true, have access to medical care, but in most cases only in the late stages of illness and in such high-cost settings as emergency rooms (Abraham 1993). Limited access is reflected in unusually

high in-hospital mortality rates and in the need for hospitalization for illnesses that, when patients are insured, are often controlled, if not cured, by means of medication or other treatment prescribed in office visits. For example, the uninsured are twice as likely as the insured to be treated in a hospital setting for diabetes.

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). All too often, however, that is not the case. Typically, the need is recognized tragically late—for example, when the leg has to be amputated or the retina is ruined because of diabetes, rather than when the disease might have been easily controlled. Indeed, for rationing by price to endure, misperceptions about what constitutes real need must be maintained.

In a world of managed care, even the characteristically too-little and too-late care of the uninsured poor has been put at risk as a result of the financial stress hospitals face. 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). And 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. Now 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. Founded as eleemosynary institutions, they are now confused as to what they are and how they are to act (Schramm 1993). The comforting, even self-justifying, axiom "no margin, no mission" is perilously close to turning into "if mission, no margin." Proliferating mergers may well help some hospitals defend themselves from the depression of fees, but they are unlikely to restore the redistributive role hospitals played in American life in the past.

Public hospitals, meanwhile, 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. What is more, public support has fallen because of the resulting perception of inefficiency and ineptitude.

Never well funded, county and municipal hospitals have become even more financially strapped as states and localities, like employers, have retreated from earlier commitments.

Moral Hazard

The high cost of American health care—and the consequent inability of many to afford health insurance—can be viewed as the inevitable by-product of the method the nation stumbled on for financing it. 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). But it is an especially large threat when premiums can be paid out of pretax income. An added problem with employment-based health insurance is that the consumer is hard to identify. The normal producer-consumer relationship is muddled by the quasi-consumer role of employers—also a natural outcome of the tax exclusion.

Because of the exclusion, employees have more health insurance (and more income in the form of insurance) than they otherwise would. The insurance, if at all comprehensive, buys two services. One is protection against the financial consequences of a major unforeseen illness, a reasonable use of insurance to spread risk. The other is 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 in any real sense, but a form of tax-free compensation. The exclusion justifies the costs of using an insurance model; those costs would never be justified otherwise, as they are on top of the thoroughly predictable expenses that must be borne in any case.

The arena in which moral hazard holds sway is thus broad, extending even to such routine things as teeth cleaning, treatment for head colds, and the bandaging of scraped knees—all high-probability but low-consequence events. Indeed, the exclusion pushed health insurance in the direction of increasingly comprehensive benefits and, then, as moral hazard would have confidently predicted, overuse of those benefits as if "free." This is hardly surprising. The effect of the exclusion on the choice between two insurance plans, one comprehensive and the other less so, is to lower the cost difference between the two by the marginal

tax rate—some 30 percent to 40 percent for most taxpayers if Social Security taxes are added to income taxes in the count.

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 choices about pursuing 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.[2]

The effect of tax-favored medical insurance is to spur new types of treatment that are better than the ones they replace, but also considerably more costly. As long as the insured patient does not confront out-of-pocket costs, the benefit-cost ratio of the new treatment has to fall to zero to make that treatment uneconomic from his or her perspective. Strikingly, the RAND Health Insurance Experiment, conducted throughout the country in the 1970s and 1980s, concluded that a $1,000 out-of-pocket deductible on a family plan reduced expenditures in the range of 25 percent to 30 percent relative to a plan without a deductible (Newhouse and The Insurance Experiment Group 1993).

Moral hazard in employment-based health insurance and in Medicare and Medicaid spurred costs all the more in concert with fee-for-service medicine and retrospective payments. Employers and government—at least until the 1980s—were largely passive in their role as agents, ceding to physicians decision making on the demand as well as the supply side of the "market."[3] And so were insurance companies. Reimbursement on the basis of actual costs tended to lead to many advances in technology that would yield some benefit but only at high cost. And it was an invitation to use those advances intensively. R&D was influenced by expected utilization, and the resulting technologies, in turn, expanded the demand for insurance. "If, for example," concluded one analysis of the interplay of health care R&D and reimbursement, "decision makers in the R&D sector believed that the development of a particular technology that was costly yet effective would cause government (and subsequently private payers) to expand insurance to cover it—as was done with kidney dialysis—there [was] . . . an incentive to develop the product even though it was not covered under existing insurance" (Weisbrod 1991).

Canons of Tax Equity

Apart from its effect on moral hazard, the exclusion violates canons of tax equity. The tax benefits rise with the employee's tax bracket, the comprehensiveness of his or her insurance plan, and the share paid by the employer. All three act against the principle of vertical tax equity to make 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, the exclusion provides employees in the income range of $100,000 to $200,000 per year an average tax subsidy in the neighborhood of $2,000, as much as the average cost of health insurance for families with $10,000 in wages (Congressional Budget Office 1994). Horizontal tax equity, which calls for equal taxation of equal income, is also violated; 100 percent of employer-paid health insurance is exempt from taxation, whereas only 30 percent is exempt if the insurance is paid by a self-employed person on his own behalf. (This inequity was recognized in the portability legislation, which provides for a gradual rise in the tax exemption for the insurance premiums of self-employed people to 80 percent by the year 2006. This is in line with the tax treatment of employees, who although they enjoy a 100 percent exclusion on the amount employers pay on their behalf, typically pay some of their own health insurance costs out-of-pocket with after-tax income. But vertical tax inequity remains if a taxpayer is not employed.)

Medical savings accounts are similarly flawed, as are so-called flexcomp accounts, which permit employees to make co-payments and pay for noncovered health-related items, such as prescription eyeglasses and cosmetic surgery, out of before-tax income. Both features of the tax code can be counted on to boost health care costs by broadening the arena over which moral hazard holds sway. They both also violate canons of tax equity and, no different from any other tax expenditure, require general tax rates to be higher than they otherwise would be.

Use of the Nation's Resources

Yet another reason why American medical care has become high-cost (relative to the standards of the past and to those of other industrial countries) is the nation's reliance on medicine to deal with what, at bottom, are broader problems. All too often, medicine rather than social

policy—by default rather than by design—has been the locus for dealing with urban violence, teen-age pregnancy, and other symptoms of the interplay of social disorder and poverty. And, all too often, medicine has done a bad, as well as a costly, job of it. For example, the United States as a whole ranks highest among developed countries in infant mortality rate (and compares unfavorably even with many developing countries). Even so, in high-income states this and other measures of public health standards compare favorably with the rest of the industrial world's (Schwartz 1995).

The concern often voiced about the cost of American health care, by business in particular, is that the nation's competitiveness suffers as a result. That is far from the real issue, however. Because it is in lieu of, not in addition to, wages and other benefits that otherwise would be paid, health insurance is but one aspect of labor cost. In any case, countries with whom the United States competes internationally typically have significantly higher fringe benefits.

The real issue is alternative uses of resources—whether for education, other investment, remedy for the nation's social dysfunction, or any other purpose. A rise in health care expenditures faster than in expenditures as a whole "crowds out" other expenditures—a truism, to be sure, but one rarely given enough emphasis in discussion as to why containing health care outlays is important. 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.

Cost control, in particular, would provide scope for dealing with the problem of the uninsured. At the very least, it would ease the resource constraint that has been at the heart of the failure—by several of its predecessors as well as by the Clinton administration—to achieve universal coverage.

It is not that the 14 percent of the nation's GDP dedicated to health care is "too high" in some absolute sense (Levit et al. 1994). That level would be hard to quarrel with if it were the outcome of after-tax spending decisions. The country, instead, has both too little and too much health care—the natural outcome of spotty public programs for the poor and widespread use of tax-free financing for most of the rest of the population. Because of subsidization through the tax system, the price of

health insurance (and thus of the underlying medical care) has become inflated, causing it to become unaffordable for too many people while it remains underpriced for most others. The institutional structure that has priced so many out of the health insurance market has made it difficult, if not prohibitive, to care for them at public expense (Havighurst 1995).

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

The tax-subsidized, employment-based health insurance that has made American medical care inordinately expensive and, in the process, exclusionary is now dated, linked as it is to a model of the labor market that no longer reflects reality. Not only are many low-income workers left out, but those who benefit from employment-based health insurance often find their freedom of choice highly restricted. Historically, the pattern has been for employers to choose the kind of medical plan their employees themselves would have opted for—no surprise considering how fringe benefits have been used to attract and hold skilled employees. Now, as part of a broader business strategy to control health care costs, many employees have been compelled to join HMOs.

A reasonable alternative—one that holds out promise of controlling costs as well as providing protection to the uninsured—is to require people to have health insurance and to subsidize it as necessary. They would obtain insurance as individuals rather than as employees (although, as discussed later, many employers would continue to provide insurance to their employees or otherwise assist them in buying insurance). The insurance would be paid for out of after-tax income, subsidized as necessary by a tax credit, which could be financed by ending the exclusion.

Taxation of employment-based health insurance would not be all that new. For the past several years the imputed value of life insurance benefits in excess of $50,000, paid as part of an employee's overall compensation, has been subject to tax. And the original justification for the exclusion (that the income is hard to identify in group health insurance) is no longer valid. So-called COBRA plans can be valued; indeed, they must be valued in order for the former employee to be billed. (Named after the Combined Omnibus Budget Reconciliation Act of 1985,

COBRA plans have made health insurance portable for more than a decade, although at employees' own expense and only for 18 months.) Also possible to value are plans that offer employees a chance to choose among an HMO, a low-deductible indemnity plan, and one with a high deductible.

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).[4] According to that plan, families with income at or near poverty level 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.

A requirement that people carry health insurance may seem burdensome. It is no more so, however, than the requirement that car owners carry liability insurance because an uninsured driver represents an unfair potential cost to everyone else on the road. A mandate is needed to prevent people from self-insuring and effectively passing on the cost of their medical care, when it become financially ruinous to them personally, to society at large. And it 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 freedom than it would have been in an earlier age when employees had greater choice of medical insurance than they have now in an age of the HMO.

Fashioning a Basic Plan

A health care reform plan that would gear tax subsidies to need and, at the same time, be revenue-neutral would have to weigh a number of trade-offs. Most important considerations are the size of the tax credit that would apply at the lowest income levels, the scope of the medical services to be covered under a basic plan, and the size of the subsidy appropriate at other income levels. It is clear, however, that 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 plus the $5 billion of revenue lost that year to state treasuries. The budgetary resources to fund a tax credit could also count on the $11 billion per year that Washington disburses to hospitals in "disproportionate share funds" to assist them in the payment of uncompensated care and on matching funds and similar support from state treasuries.[5] With universal coverage, such assistance would no longer be necessary.

However complex the trade-offs, the principles of retargeting the subsidies are straightforward. As with any redistribution of income, the political process would have to find a way to balance the interests of the beneficiaries against those of the payers (indeed, every public service and every benefit program must strike such a balance). The credit would have to be high enough to provide genuine coverage (the diabetes would be treated at onset) and yet not so high as to underwrite the kind of medical care that most unsubsidized consumers would forgo for themselves, especially if they had to pay for it with after-tax dollars. Extending health insurance to all would not mean providing all the health care that it is technically possible to provide. But it would mean that all Americans would have access to a minimum level of adequate, basic care. No one would be constrained from buying insurance that provided a deeper set of services, although all such insurance would have to be paid for with after-tax dollars.

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 Oregon, Washington, and other states that have given serious thought to the kind of services government ought to make available when state funds are used in paying medical bills. Existing Medicaid coverage could also be the basis for the design of a basic federal plan.

The federal government's role would be to ensure that plans funded by the tax credit meet minimal standards of protection for subscribers. It would also be to channel high-risk subscribers to insurance pools and to

subsidize 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—laws that have been important in raising health care costs and that also have worked to the disadvantage of employees of small firms. As a practical matter, those firms cannot avoid state mandates (and also state taxes on health insurance) by self-insuring under ERISA (Employment Retirement Income Security Act), the federal law that circumscribes state power in the design of employee benefits.

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, ending at a stroke the horizontal and the vertical inequity in the tax exclusion. 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 fund for themselves without risk of catastrophic financial loss. This means that no deductibles or other co-payments would be required at relatively low income levels; the credit in that case 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 insured would pay the rest of whatever health insurance they obtain plus any deductibles and other co-payments out of after-tax income. As income rises further, the credit would fall to zero; all of the cost of health insurance plus co-payments would come from after-tax income.

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.[6] 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).

Not only would the amount of the credit vary with income, so also would the required health insurance. All that would be required is that a family have enough insurance to meet unforeseen medical bills without stretching its financial resources unduly—that it have "catastrophic" coverage. Alternatively, people at all income levels (including those well-heeled enough to self-insure) would be required to purchase the basic package.[7]

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.

A range of administrative issues would have to be decided: what counts as income and what does not, the nature of penalties to enforce the individual mandate, how to disburse credits 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.

A Well-Functioning Health Insurance Market

Ending the tax exclusion and replacing it with, in effect, an income-scaled voucher would alter the health insurance market in a variety of ways. In so doing, it would have major implications for health care delivery. 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 out less expensive insurance. The change would push the health insurance market toward catastrophic coverage, featuring high deductibles and other co-payments, thus economizing on the claims processing and other administrative costs now associated with the use of insurance for the payment of routine and predictable expenses. It thus would reduce moral hazard and, in turn, the pressure on costs ensuing from the illusion that medical care is somehow free or, at the very least, not to be valued at its

full cost. Individual, high co-payment policies would offer a good alternative to an HMO to employees who now have little, if any, choice.

With such a change, health insurance would come to be viewed not as an entitlement linked to a job, but as real insurance—protection against chance but potentially devastating financial consequences. It would be "last-dollar" (catastrophic), not "first-dollar" (ordinary expense), coverage. The plan, in short, would go far beyond budgetary neutrality to promise real economies in the use of resources.

The ad hoc subsidies now flowing through hospital bills (which are ultimately paid for by society at large) would be made explicit and transparent. And there would be better balance between routine and emergency care. Just as with any other universal plan, the care given to the uninsured who cannot afford to pay for it would be provided earlier and in much less costly settings.

A requirement that all be insured would remedy the problem of adverse selection, which along with moral hazard is endemic to insurance. Because of adverse selection, low risks tend to self-insure, thereby pushing up costs for those left in the insurance pool; high risks tend to overinsure, with similar effect on costs. With a mandate, however, each insurer would "expect to get a random slice of all risks, and there is no need to charge a premium higher than the average expected for a given risk class," write Pauly and his associates in support of their plan (Pauly, Danzon, Feldstein, and Hoff 1993).

A mandate thus would push the health insurance market in the direction of renewable, long-term, contracts—the essence of community rating. When insurance is voluntary, such a model is unstable, but it is not unstable when insurance is universal. A mandate, of course, would not make health insurance affordable for the working poor (it would have to be attached to a tax credit or other subsidies). But it would undo the breakdown of the individual and small-group insurance market that has prevented others from obtaining affordable coverage. Indeed, universal coverage may well be essential to a well-functioning health insurance market. Without it, risk rating drives out the sick, making coverage prohibitively expensive for them to maintain, thus defeating the whole purpose of insurance. And, without universal coverage, community rating drives out the healthy, as it raise average prices.

A More Efficient Labor Market

Severing the link between health insurance and a job would go far beyond portability in breaking job-lock. Today's financing of health care has produced a form of insurance that is basically a term, rather than a renewable, product. It yields security only as long as the job lasts. It also discriminates against the young, the unskilled, and others with relatively high job turnover. The overall efficiency of the labor market would also benefit if the tax rates of the salaried and the self-employed were on the same footing (indeed, if tax equity canons were observed all around), if the discrimination that keeps people out of a job because their potential employer's health care costs might soar were ended, and if decisions to retire before age 65 when Medicare becomes applicable were not so affected by health insurance considerations.

A key question is whether employers would continue to play a major role in health insurance if they were no longer able to leverage labor costs by means of the tax exclusion. They would have less incentive to provide coverage or even to act merely as sponsors of insurance plans (evaluating plans on behalf of their employees, collecting premiums, and otherwise overseeing the functioning of the plans). Even so, some incentive would remain. Employers, especially those of any size, are uniquely qualified to process information about insurance contracts on behalf of their employees. Group health insurance, moreover, even if paid out of taxable income, 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—perhaps the only real virtue of an employment-based system. Employers and employees would benefit on all three counts from continued employer provision of health insurance (just as they both do in the case of taxable life insurance) or, failing that, from employer sponsorship of plans.

Alternatively, unions, trade and professional associations, other nonprofit organizations, or government itself would have to assume a larger sponsorship role. Or new sponsors would have to emerge: churches, civic organizations, and other community groups that can naturally pool risk.[8] Such sponsors would have to undertake the role corporate benefits officers now play if business were to retreat from sponsorship of health insurance because of the end of the tax exclusion.

Cost Savings: Two Views

How health care expenditures would be affected by replacing the tax exclusion with a credit is hard to judge. Even so, 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 of the effect of ending the exclusion 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. The 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. And they point up the advances in technology that have both blessed (on the care side) and cursed (on the cost side) American medicine. Such advances may be the main driver of U.S. health care costs, but they did not develop in an institutional vacuum. At least in part, they are the product of a highly subsidized funding regime, with its misplaced incentives for overuse of medical care not just for cases all too often beyond reasonable hope, but for a large majority of the population as well.

A better tax system would change the benefit-cost ratios for a wide range of medical interventions. And it would avoid the waste of using insurance claims to pay for routine care. But it cannot be expected to offer guidance on the volume of resources to be dedicated to a grossly

underweight newborn or to a 70-year-old in dire need of a new heart or kidney. No matter how sound the tax treatment of medical care costs, such ethical questions (which go to the community's as well as the individual's claim on scarce resources) will remain. Indeed, those questions will become even harder to answer in the future if, as expected, health care once again starts to account for a rising share of GDP. Even taking into account the deceleration in health care spending in the past several years, health care is projected to consume 18 percent of GDP by the year 2005 (Burner and Waldo 1995). And the ratio is almost certain to trend higher thereafter because of the aging of the postwar baby boom. Even if the health care delivery system were to stay as it is, per capita health care utilization is projected to rise about 25 percent above current levels simply because of an older population (Schieber and Shoven 1996).

Alternative Approaches

Universality could be achieved through a variety of means other than a tax credit. All of them, however, are flawed in one way or another. The Clinton administration's proposed "pay-or-play" (which requires employers to provide health insurance, that is, to participate, or to pay into a public plan) is regressive in its implicit payroll taxation of those at the bottom of the income distribution. Since health insurance is, in fact, paid by employees and not by employers, pay-or-play effectively compels low-wage employees to dedicate an inordinately large share of their income to health care. And it perpetuates the fiction that it is the employer and not the employee who pays the bill.

Pay-or-play also encourages employers to find ways to manipulate the system, for example, by switching from full-time workers to part-time workers, who as a practical matter would not be covered, and by opting to "pay" because of the benefits they may glean from the subsidies to small firms that have been a feature of the public plans employers could choose to pay into. Such an approach is wide of the mark in viewing the size of firm, rather than the income of the employee, as the key problem of the uninsured. Pay-or-play, moreover, further institutionalizes employment-based health insurance in a labor market increasingly at odds with the permanence needed to make such a system work well for much of the workforce. It would have to be supplemented with cumbersome programs to extend health insurance to nonemployees and part-time workers.

All-payer systems along the lines of the Canadian model are said to be administratively simple and thus channel more of the health care dollar to actual patient care. Much of the cost of public monopoly systems is hidden, however. 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.

Budget constraints at the level of the local Canadian hospital have frequently spelled inordinately long delays for surgical procedures. And limits on physician fees have meant several short visits for patients with illnesses more efficiently treated at one go. "The rough empirical evidence," writes Patricia Danzon (1993), "tends to confirm that overhead costs in Canada, adjusted to include some of the most significant hidden costs, are indeed higher than under private insurance in the United States. Although there may be waste in U.S. private insurance markets at present, this waste is attributable primarily to tax and regulatory factors (such as the tax exclusion) and is not intrinsic to private health insurance."

Even if the Canadian model had the edge on overhead, it would be hard to replicate in the United States (especially now that fee-for-service medicine, which is essential to the model, is in decline). Shifting to the public sector the 8 percent of GDP that private health care represents out of the total of 14 percent is the biggest problem of all in a country wary of government—the key reason why the Clinton administration, however much it might have been tempted by the Canadian model, apparently rejected it a priori.

Medicaid buy-ins (which allow those not quite poor enough to qualify for Medicaid to do so by paying part of the cost) would resurrect Medicaid's original design for the inclusion of all low-income households in medical care plans not unlike the general population's. They 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 they would leave employment-based health insurance, with its growing insecurity for much of the workforce, intact.

Integrating Medicaid and Medicare into a Tax-Credit Plan

These considerations point to grafting health insurance tax credits onto Medicaid rather than to enlarging Medicaid itself. The advantage of this approach is that it would eliminate the disincentive Medicaid recipients now have to find a job lest they lose their health care (the so-called notch problem). The disincentive will have to be addressed if there is to be a serious national effort to move people off welfare and into work. A health insurance tax credit for the working poor (they would be the main beneficiaries) is functionally the same as the earned income tax credit, although it would be earmarked for an expenditure of broad social as well as individual benefit.

Tax credits would not, it is true, meet the health care needs of many of the nonworking indigent—the deinstitutionalized mentally ill and other "walking wounded"—who make up almost a quarter of the uninsured. There would remain a need to develop walk-in clinics and otherwise devote resources to "poverty medicine" (Hilfiker 1994). The United States would do well to take a lesson from Japan, where public health facilities are widely used for prenatal care, immunizations, and a few other critical interventions. Poverty medicine can do only so much, however. The problems are far upstream of even the best designed health care institutions. If they are to be addressed, they will have to be addressed through plans designed to deal with poverty itself, rather than through instrumentalities that can do little about them.

Medicare also could be brought into a credit arrangement, and it probably ought to be on the principle that subsidies for health care should be based on need for the elderly population no less than for the population at large. A heavily subsidized health care plan that is blind to income for all over the age of 64 may have made sense in the mid 1960s. Health care was 6 percent of GDP; the average income of the elderly was significantly below that of the population at large; and life expectancies were lower than they are today. But the approach that may have been reasonable 30 years ago has never been seriously reexamined in light of vastly changed circumstances. Subsidization has become deeper over the years as beneficiaries (even those at high income) have come to pay an even smaller share of overall Medicare costs.

It would be unreasonable—indeed unfair—to cut back on the tax subsidies to health care attached to employment for those at relatively high income and yet leave alone the subsidies provided through Medicare for a similarly well-heeled population. Lamentably, however, the Medicare debate has been focused on fiscal aggregates rather than on the level of subsidy that beneficiaries ought to receive. In practice, that approach means top-down budgeting and continued squeezing of the incomes of hospitals and physicians—at the risk of loss of quality that would harm not only Medicare beneficiaries but the population at large.

The underlying premise of the debate has been that cuts from baseline budgets should affect beneficiaries evenly rather than be targeted to groups less in need of subsidization than others. Too little consideration has been given, for example, to linking premiums to ability to pay—something that would offset some of the fiscal squeeze in the offing. For example, Part B premiums, which cover physician bills, could be raised substantially for relatively high-income beneficiaries without even reaching the 50 percent share of the cost of Part B those premiums were supposed to finance when Medicare was first established.

Broader reform might well include integration of Part A (which covers hospitalization expenses and is fully funded by payroll taxes) and Part B (which today is 75 percent funded by general revenue, 25 percent by beneficiary premiums). There is little, if any, reason to distinguish between Parts A and B or to finance them from different sources. The rationale all along has been that Part B is voluntary. But, with participation in Part B effectively 100 percent because the program is so highly subsidized, the distinction is meaningless. To the extent there is a public interest in subsidizing medical care for the elderly, that interest extends across the whole range of covered medical services (Aaron and Reischauer 1995).

Integrating the two Medicare programs would provide an opportunity to take a step in the direction of the principle of ability to pay, paralleling the design of the tax credit. And it would be occasion to move to a voucher or premium-support system, also paralleling the design of the tax credit. The premiums of a combined program could be keyed to the income of beneficiaries, and, depending again on income level, vouchers could be considered partly or wholly taxable income.

Integrating the public programs into a tax-credit plan, or at least putting them on a comparable footing based on the principle of 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

Prospects for significant reform of American institutions are rarely bright, but there are times when real change seems possible, as it did for health care in the early days of the Clinton administration. It then seemed possible to marshal widespread political support for universal coverage if the coverage could be linked to middle-class concern about the growing insecurity of employment-based health insurance.

The anxieties and uncertainties the Clinton plan itself gave rise to no doubt contributed to its rejection in Congress. The plan's inclusiveness—with its provision, for example, for long-term care, drug costs, and early-retiree insurance—drove up potential costs, and there was concern that promised savings in health care delivery would not materialize at all early enough to pay those costs. Damage was inflicted by Harry and Louise, the characters in a series of advertisements expressing the views of traditional indemnity insurers, who were fearful of the plan's emphasis on managed care and community rating. The media, unable to make sense out of the inevitably complex issues, failed to provide much of a foil to balance the distortions the image makers succeeded in getting across.

Ultimately, however, it was the Clinton administration's Republican adversaries who brought down the plan. By labeling pay-or-play as implicit taxation, they exploited the mistrust of government. Only a few constituencies were ready to do battle for the plan and fewer still had ample resources and the voice to do so.

Universal care advocates have made some progress at state houses, but it has been slow going, for the same fundamental reasons the Clinton plan foundered: the practical political difficulty of raising the revenue to cover the uninsured and the opposition of employers and of small but

powerful constituencies with little to gain and much to lose from the cost control needed to make universal coverage work. Questions of who pays and who wins or loses have proved no easier to answer at the state level than at the federal level.[9]

Health care reform of any size and scope is off the policy agenda for now. Understandably, Democrats are reluctant to embrace anything beyond such minor changes as portability. Republicans are also fearful, particularly of making of Medicare a "third rail" political issue of the kind Social Security retirement has become over the years. They must, however, push for substantial reductions in Medicare and in Medicaid baseline budgets if their embrace of deficit reduction at large is to be at all credible.

All the same, health care reform is apt to resurface as a major national issue in the next few years. The growing ranks of the uninsured, the cost consequences of misdirected subsidies, the breakdown of the individual and small-group insurance market—none of these will have gone away. The clash in the workplace arising out of growing restriction on the kind of insurance plan employees may choose will still be there as well. The next time round, replacing the tax exclusion with a tax credit may well get a serious hearing. It addresses all of these issues and promises to help control health care costs through the economical choice of an insurance plan.

Building a constituency for a tax-credit plan will not be easy. The idea has not been accepted among those on the right, who typically have viewed the credit as a tax increase (not only an increase, but one that would make the federal tax system slightly more progressive than it is now). Those on the left, who often misconstrue the concept of entitlement, typically have been opposed on grounds that health care benefits were negotiated in lieu of wages, and it would be unfair to lessen the value of those benefits by making them taxable.

A constituency can be fashioned, however. The point to be stressed most 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 as well. Moreover, those who would benefit from

a credit, net of a lost tax exclusion, would extend well into the middle-income groups, judging by the calculations of both the CBO and Pauly and his associates. Even many high-income people, who would be net losers looking narrowly at their tax returns, would benefit by seeking cost-efficient health insurance. They would be 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, however. They would have to be 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. The appeal would have to be to the axiom of Adam Smith that an individual genuinely prospers only in a prosperous society.

Corporate America could well form part of the constituency to move to individual-based health insurance. It has benefited from the leveraging of compensation costs made possible by the exclusion. But it is not well served by the damage to morale and to employee relations generally that has come about because of the need to control health care costs, a need rooted in the tax-free way the nation has financed much of its health care. Being "the heavy" when employees feel they have been denied needed care for themselves or a member of their family is not a role Corporate America could possibly want. 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.

Much the same 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.

No health reform is apt to get very far, however, if it is framed in the basically dishonest public discourse of today. A tax credit or any other

means of financing universal health care involves a redistribution of income. That has to be acknowledged from the start. The case for it can be made on grounds of efficiency and tax fairness. But it would be more convincing if the political establishment is willing to make the case for health care as a basic human right—not to be parceled out like Chevrolets or other goods and services best distributed only by the laws of the marketplace. 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 put forth in a clear voice.

Notes

1. Even now, cuts in Medicaid reimbursement pose significant risk to the health care of beneficiaries, observes Stephen Felsted, chief financial officer of the Holy Cross Health System: "In our hospital in Fresno, for example, the MediCal capitation [flat] rate, covering people in relatively poor health, has been reduced to $66.50 per member per month, $18 to $20 of which goes to hospitals. The amounts are about half the rate paid for a healthy 'commercial' population. It is no wonder our systems cannot cope. And there is growing threat to access in the form of second-tier delivery systems and Medicaid mills where physicians are forced to see between 60 and 70 patients a day, twice as many as in a commercial primary care practice" (personal communication 1996).
2. Felsted makes this observation about the Holy Cross Health System's hospital 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).
3. George Bernard Shaw was among fee-for-service's sternest critics: "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg is enough to make one despair of political humanity" (Shaw 1963).
4. 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 formed 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 of replacing the tax exclusion with a credit.

5. Telephone conversation with John Sheils, The Lewin Group, June 12, 1996.
6. 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.
7. The principle that all carry health insurance designed to rule out catastrophic financial loss would theoretically exempt a Rockefeller or others who have virtually unlimited resources. It would not be necessary for them to be insured to prevent them from becoming free riders on the system. It presumably would be necessary, however, as a matter of practical politics, just as it is in the case of mandatory automobile insurance.
8. Conversation with Robert E. Moffit of the Heritage Foundation, February 23, 1996.
9. Minnesota, Oregon, Washington, and Massachusetts all have backtracked on fiscal grounds from plans to cover the uninsured with pay-or-play mandates or Medicaid buy-ins. ERISA has also been a stumbling block. Tennessee has enrolled the uninsured in state-subsidized HMOs, although there are questions about the quality of care at many of the participating organizations. Hawaii has had a pay-or-play plan in force since the 1970s, although it still does not cover dependents.

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About the Author

Senior Fellow Walter M. Cadette's areas of special interest include health care, international trade, and regulation of financial institutions. He is currently examining proposals to put Social Security on long-run sound financial footing. In addition to his work at the Levy Institute, Cadette is chairman of the Holy Cross Health System's investment review committee, which has oversight responsibility for a $1 billion portfolio. Cadette is a retired vice president and senior economist of J.P. Morgan & Co. Incorporated and was editor of and contributor to the bank's publications *Global Data Watch* and *World Financial Markets*. He also taught at the School of International and Public Affairs at Columbia University. He received an M.A. from Georgetown University and did further graduate work in economics and finance at New York University.