A Workable Social Insurance Approach to Expanding Health Insurance Coverage

by C. Eugene Steuerle

Introduction

The federal government's health budget is expanding by leaps and bounds even as the number of uninsured increases and average out-of-pocket costs for Americans rise faster than income. Does this seem incongruous? It shouldn't. Federal policy toward health care operates like a man running with a blindfold on: that he trips, falls over cliffs, and generally fails to reach his objective shouldn't be surprising. What is questionable is the federal government's continual exhortation to run faster under these circumstances. If the blindfold comes off, then policy can be "run" at a more sustainable and efficient pace.

The task here, to identify ways to expand health insurance coverage and reduce the number of uninsured, cannot be achieved without squarely facing the constraints and dilemmas of health policy. Here, the non-health side of the wider market and the financing side of government must be given their due. That is, government expenditures on health care are one part of a broader balance sheet; the other parts of that sheet change simultaneously when health policy is reformed. Ignoring them will not make them go away.

The growth in federal expenditures on health care is so large today that it claims a major share of all new revenues to the government and has led, over time, to a decline in the share of almost all non-health functions, other than retirement, relative to both total expenditures and gross domestic product (GDP). Spending more on new health programs on top of the automatic growth in existing programs *does* mean less to spend on education, homeland security, community development, and everything else—in the aggregate and, often, separately. The high level of current expenditures helps to make reform very difficult, because change can be very expensive and affects a wide range of interest groups.

Even if one wants to argue that tax increases can meet demands for new public interventions (that is, that privately paid-for goods and services, rather than other public goods and services, are what should decrease), this scenario still gives health care priority to use those government revenues and weakens the ability of other functions to maintain their current resource shares, much less capture some higher future share.[109]

This situation is not as bleak as it might first appear. Although the high, automatic, growth rate in existing health care entitlement programs—a growth requiring no new legislation—greatly constrains achieving legislative reforms, those constraints are more political than economic. Indeed, the political problem is how to move off a path of unsustainable promises, but the economic problem is how to

[109] Higher tax rates raise the efficiency cost, even for the same level of expenditure on other functions. That is, economic theory suggests that at the margin, the efficiency cost of taxes rises with the tax rate. Hence, if education programs require tax rates to rise from 35 to 36 percent, they are more costly in terms of efficiency than if they require tax rates to rise from 25 to 26 percent. Even if one does not accept the economic logic, it is fairly clear that taxpayers reduce their support for government functions at higher tax rates. Either way, large amounts spent on health care weaken legislators' ability to tap taxpayers yet again for non-health purposes. Trade-offs are real.

capture some of the sustainable portion of public health expenditure growth and steer it toward more optimal use. Here, much can be achieved.

While some components of the reform package set out here are similar to those in other proposals, this paper approaches the task by recognizing up-front all parts of the health care balance sheet. Thus, many health care proposals start from a health needs assessment that includes inadequate health insurance coverage. Then they blithely ignore all the dilemmas and constraints embedded in current health policy, ranging from large budgetary cost to high implicit and hidden tax rates. The approach here is, first, to identify the constraints and dilemmas and then see how a reform plan might be developed that recognizes and addresses them.

The Dilemmas and Constraints

The Budget

In the United States, government at all levels now spends a percentage of GDP on health care that is similar to that spent by government in other developed countries, although private costs are much higher in the United States. For the government simply to take over the costs of the private portion of the health care system would soon require a tax increase of about 8 percent of GDP (and more over time without a strict set of cost controls). This could translate into either 16 additional percentage points in a tax rate on earnings similar to Social Security or close to a doubling of the individual income tax. In addition, the growth rate in public health expenditures, including tax subsidies, is inexorable: projected costs of public health care subsidies and systems indicate that they will continually absorb larger shares of GDP.[110]

This growth in existing health programs is so great that it cannot be absorbed easily: facing their own budget crunch, for instance, state governments today are wary of Medicaid expansions even when a significant share of the additional cost is paid out of federal funds. Education, national defense, homeland security, and a variety of other needs create budgetary pressures that inevitably are going to force the federal government to constrain health cost growth, one way or the other. *Any simple expansion in government health expenditures sooner or later will only add to the requirement to constrain the growth of total government health care expenditures.*

Average Health Care Spending

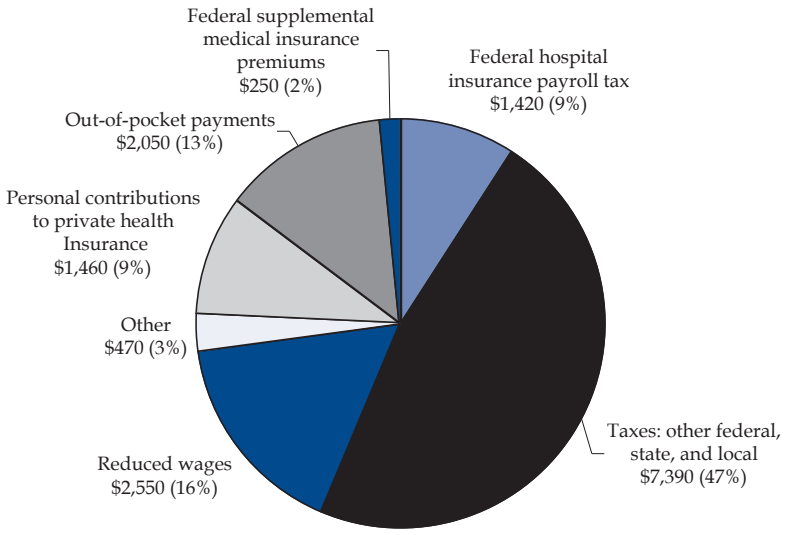
For 2003 average health care spending per U.S. household was approximately $15,600, of which less than $4,000 was paid directly out-of-pocket or as personal contributions to health insurance (see figure 1). Approximately $8,800 per household is paid through federal, state, and local taxes to fund government health programs and to compensate for revenues lost due to the special tax treatment of certain health-related income. More than $2,500 per household was paid indirectly through lower wages in return for employer-provided insurance, and around $500 was paid for through such non-patient revenue as charitable donations, hospital parking, and gift shops. *It is simply not possible to continue the myth that $1,000 or $2,000 will purchase meaningful catastrophic health coverage for a household when $15,600 is the average household health spending.*[111]

[110] See for instance Budget of the United States Government, FY 2004, Historical Tables, Table 16.1—Outlays for Health Programs, 1962-2008, p. 299; and 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 7.

[111] These calculations were first made for 1992 in C. Eugene Steuerle, "The Search for Adaptable Health Policy through Finance-based Reform," in Robert. B. Helms (ed.). *American Health Policy: Critical Issues for Reform*. Washington: AEI Press, 1993, and for 1996 in C. Eugene Steuerle and Gordon B. T. Mermin. "A Better Subsidy for Health Insurance." In Grace Marie Arnett (ed.). *Empowering Health Care Consumers through Tax Reform* (Washington, DC: the Galen Institute, Alexandria, VA: 1999). During that period, average costs rose from about $8,000 in 1992 to $11,000 in 1996 to more than $15,000 for 2003. The notion that there

FIGURE 1

Average Health Care Costs per Household by Source, 2003 (Total = $15,590)



Source: C. Eugene Steuerle, Urban Institute, 2003. Based on data from the Centers on Medicare and Medicaid and the Budget of the U.S. Government, FY 2004.

Infinite Demand at a Zero Price

Crucial to the design of health insurance has been a feature that has plagued health costs, both private and public, to this day: most individuals receive, and most health care professionals provide, services without either having to pay more than limited attention to cost. Essentially, the patient and doctor negotiate over what is paid for by *other* members of the insurance plan—in the case of Medicare, the taxpayer. In effect, public benefits have expanded without any real cap on cost except as laws and regulations (public and private) attempt to limit the services eligible for reimbursement or the reimbursement rate. Efforts to limit payments through managed care, managed competition, and capitation payments have not yet succeeded in breaking through this incentive system. Meanwhile, the higher costs lead to more people and employers opting out of insurance. *The budget burden of existing government health subsidies grows at an unsustainable rate largely because the design of health insurance often leaves decision-makers indifferent to added costs for society and discourages ratcheting down the price of existing services in ways that are common to other growth industries.*

Bang per Buck on Incremental Expansion

A variety of incremental expansions of the existing health care system are often proposed. Economists put these expansions into their various economic models, and then typically conclude they have limited bang per buck:

- Patched onto an existing labyrinth, the incremental expansion typically tries to target a harder-to-engage population.
- A new government subsidy often reduces incentives to engage in other private coverage arrangements, such as existing employer-provided health insurance. This crowd-out ef-

is no money available for reform is belied by the costs imposed simply by staying on the current path.

fect leads to a further shift from private funding to public, thus weakening the net impact of any additional public funding on provision of additional health care.

Because they are typically accompanied by shifts from the private to the public sector, most incremental expansions in government programs cost government much more than the cost of any net additional health insurance or health care received.

Who Should Be Subsidized? Who Should Pay?

If a new government subsidy system is designed so that all households with moderate incomes are to be heavily subsidized, then the cost of the program will be quite high, and a large share of that cost will go to subsidize those already insured. If, on the other hand, all moderate-income people are to be only modestly subsidized, then the complaint is that those in this income group who are currently uninsured still cannot afford to buy insurance. To complicate matters more, most moderate-income insured individuals already spend amounts that many reformers consider too high to impose on those who are not insured. Those paying already usually pay through a reduction in cash wages (at least according to most economic theory) when receiving employer-provided health insurance. *To save on costs, many proposals opt to heavily subsidize moderate-income individuals without insurance, but then they deny some or all benefits to equally deserving moderate-income taxpayers who already buy their own insurance, usually through their employers*.

Growth and Productivity within the Health Sector

Investments in health ideally should be targeted to meet the greatest need per dollar spent. Over time, constantly readjusting to new needs and new opportunities requires attention to health sector productivity. Alone among major growth sectors, the U.S. health sector maintains significant increases in quantity of production not matched by declines in relative prices.[112] (Consider, for instance, how prices drop for existing products in other growth industries, such as computers and telecommunications.) The result is very high-cost growth, which leads to more demand for public cost controls. In turn, these cost controls threaten new technologies, partly because vested interests fight to maintain higher prices for existing goods and services, thereby reducing directly or indirectly what regulators might make available to spend on newer items. Even today, we under-invest in some services that may significantly improve health and over-invest in some services with minimal, if any, positive impact on health. For instance, many forms of unsubsidized preventive health are known to yield higher returns than many forms of subsidized acute care that have little if any positive impact on health.

Within one or two decades, half of all spending on health care will be for products and services not available today. A gigantic bargaining session with government bureaucrats or elected officials, however, simply is not going to be able to determine easily what those new products and services should be in that doubly large market. The decision over what new items to produce must be determined in part by a private sector that tries to balance the costs against the benefits of the goods and services they will receive.

Put another way, if an economy is to grow optimally, resources have to be allocated to areas of production where they yield the highest net return. Under ideal conditions, freely operating markets tend to produce that result, because prices adjust so that resources command the highest price where they are most valued. But when government makes resource allocation decisions, or when buyers pay prices that are different from market-determined prices—both of which are true for many health care services—resources do not

[112] See Figure 3 in Rudolph Penner and C. Eugene Steuerle, "Budget Crisis at the Door," (Washington, DC: The Urban Institute), forthcoming.

necessarily flow to areas of greatest value. We should therefore strive, where practical, to create a structure where consumers are aware of the true resource cost and bear the burden of deciding to consume additional health resources. Of course, this is easier said than done, and we have to combine such a strategy with policies that ensure people can afford to have adequate access to high-value health services. *Health reform proposals cannot ignore the difficult requirement to choose the best health goods and services in the future—a requirement that forces individuals to face directly some of the costs of their decisions, particularly the costs of the insurance they buy.*

Engaging the Market and Adverse Selection

If direct cost controls cannot be used fully to restrain cost, then the only other real option is somehow to let individuals—or intermediaries acting on behalf of individuals—make more choices within an incentive structure that encourages economizing. However, when people are allowed choices among benefits packages, delivery systems, levels of cost sharing, and so forth, some risk segmentation almost inevitably arises. The healthy always have an incentive to pursue other healthy individuals to join with them in common risk pools, leaving the less healthy behind with much higher insurance costs or the inability to buy insurance at all. By allowing individuals to recognize cost and match benefits to prices, however, more output can be produced at a smaller cost, and market production can better match consumer preferences about how the same amount of money should be spent. Thus, productivity/efficiency and risk selection go hand in hand, a conclusion that neither proponents nor opponents of market-based reform like to admit. *Greater market efficiency through private decision making leads to some adverse selection, thus requiring a delicate balancing act.*

The Welfare Dilemma

Often what appears to be the simplest solution to expanding health insurance coverage is to adopt a welfare model and put all the money at the bottom of the income distribution, where people are least likely to have insurance on their own or to be able to afford it. Actually, to get the most at the bottom and achieve maximum progressivity means continual expansion of a system like Medicaid, with fixed income points for determining eligibility. Any alternative scheme of phasing out benefits means that a larger share of the money is spent at income levels above, and a smaller share below, some notch point where benefits are suddenly taken away. This classic welfare dilemma arises from the tax systems implicit in transfer programs. *Substantial means testing in health programs, whether through notches or phase-outs of benefits, entails many of the problems associated with welfare systems: large penalties for additional work (often one more dollar means the loss of thousands of dollars of benefits) and huge marriage penalties for groups of people for whom marriage is a route out of poverty.*

What to Do?

In sum, any proposal must operate in a world with:

- government health care costs that must be constrained;
- average health care spending well in excess of what most people (and members of Congress) think is average;
- infinite demand when health insurance offers services at zero or close-to-zero prices;
- poor bang per buck for most incremental expansions;
- subsidies for the uninsured often not granted to or proposed for other equally deserving taxpayers who get insurance from their employers or buy it on their own;
- beneficial long-term effects when people face choices and are engaged in recognizing costs along with benefits and differentiating services that make them healthy and produc-

tive versus those of lesser value;

- adverse selection and market efficiency that go hand in hand; and
- the classic welfare dilemma that: any system of phasing out benefits creates a tax system unto itself with its own set of distortions that must be addressed.

Health care proposals often ignore or fail to deal with one or more of these dilemmas or constraints. No proposal is fully developed if it ignores the existing health care budget or what people spend now, creates large adverse selection, or implicitly builds a new, large, crazy quilt tax system.

Facing up to a dilemma, however, does not mean finding an easy way around it. It simply means that one has a better chance of choosing feasible policies. Here is one example:

Research on the incremental value of any modest legislative expansion in publicly provided health coverage often shows little bang per buck. This research is not consistent, however. It is not the analysis that fails, but what is analyzed. In particular, there appear to be no studies of the marginal impact on coverage of expansions that take place *automatically.* Consider the increasing amount of tax revenue spent to cover the existing, uncapped, employee tax exclusion for employer-provided insurance. Here is an expansion that *reduces* the number of insured and costs taxpayers more each year. That is, the uncapped tax exclusion helps promote higher costs for health insurance, which in turn causes fewer people to buy insurance. If the incremental tax dollars foregone because of the employee exclusion were transferred to a more universal credit that was capped, there could be a net reduction in the number of uninsured at no additional cost. Put another way, the "bang per buck" analysis can be used to guide *relative* shifts in priorities even if most absolute increases in health care spending can be shown to yield very modest net gains per dollar of additional cost.

In simplest terms, I believe one must engage the dilemmas, recognize the validity of concerns that drive each side of each dilemma, and then tackle the trade-offs that are required.

In a world of trade-offs:

- expenditure-neutral and revenue-neutral options are considered;
- the marginal impact of automatic growth is not ignored but juxtaposed with policy alternatives;
- carrots and sticks are considered simultaneously, taking into account various inequities (those who pay more than others who are in equal circumstances);
- the constraints of limited resources and limited ability to create perfect equality or avoid all adverse selection are recognized; and
- the regulatory nature of any insurance scheme, private or public—its effects on the demand for health insurance, market growth, adverse selection, and tax systems—is engaged, not disdained.

A Reform Package

The package of reforms offered below is directed at taxpayers at all income levels but is not meant to be an all-encompassing solution to providing universal health care. Nor is it meant to be a replacement for a Medicaid or a welfare-type system for those with low incomes, although one could build on the basic package to develop a replacement. Moreover, it extends its reach to many low- and moderate-income people who fall through the cracks of all systems. For instance, Medicaid leaves out large numbers of single people and households that, although eligible, simply do not apply for Medicaid (either directly or by way of cash assistance programs like Temporary Assistance to Needy Families (TANF), whose administrators often tie beneficiaries into the Medicaid system).

What this proposal seeks to do is gradually replace the principal existing system of sup-

port now provided largely to moderate- to high-income people in a way that increases insurance coverage, leads to greater cost constraints, and otherwise creates market incentives for a more efficient, yet growing, health market. This approach also recognizes the need to engage people in the broad middle class in the ways they receive most health care and pay for most health insurance, whether through taxes, reduced wages, or direct purchase. It seeks to engage them more actively in making decisions, especially about purchasing insurance, in ways that would improve the efficiency of the health market for everyone. Improvements in the base system that applies to most taxpayers make it easier to integrate a reformed Medicaid system with the type of credit-based system suggested here.

Finally, this proposal is perhaps unique in showing that it is possible to improve the efficiency and equity of the system without adding to cost, although it may be desirable to incur some additional costs under the reformed model to increase the size of subsidies.

Social Insurance and Mandates

The crux of this reform package is its attempt to move health insurance subsidies into a system of social insurance in a consistent and coherent way. Unlike a welfare approach, social insurance deals directly with the obligation to pay, not just the need to receive. There is not enough room here to engage fully this important distinction.[113] Nonetheless, some brief comments are in order.

Although health reformers often advocate subsidizing health insurance, especially for low-income individuals, such a policy really involves two separate goals. The first is helping individuals have enough income to purchase health insurance, and the second is requiring individuals to purchase health insurance (since the subsidy cannot be used to purchase any other good or service). Each goal—greater progressivity (achieved by subsidies) and mandated health insurance coverage—must be justified in its own right. Even in the case of an insured Medicaid enrollee, it is not automatic that the amount spent on health insurance has greater societal value than other uses of the funds, such as a better education or more clothing.

Similarly, subsidizing health insurance at moderate- to high-income levels mixes two goals, the subsidy and the mandate that it be spent on health insurance. When these goals are separated, it becomes obvious that the employee exclusion for employer-provided health care is not progressive at all, since it distributes much more to the rich than the poor. Moreover, a little-known but telling fact is that it is becoming more regressive over time as more moderate-income individuals fall out of the employer-provided insurance market. Yet, one may still want to coax, through subsidies or mandates, insurance coverage at middle- and high-income levels. In effect, income redistribution as a goal of policy can be separated from requiring or encouraging people to buy health insurance.

The ability of some individuals to ride free on others' tax and insurance payments is a problem that applies to all income levels. Those who are not insured, even if they have average incomes, bear some risk that they will be unable to pay a large or catastrophic expense. This expense may then be met out of public funds (for instance, if the expense makes them eligible for Medicaid) or private funds (if private insurance helps cover the cost of uncompensated emergency care in hospitals). Hence, not all the "uninsured" are entirely uninsured: many effectively have a backup insurance policy that is paid for either by the insured or other taxpayers. For people with low to moderate income levels, the cost of buying insurance is high relative to income, while their lack of private resources means that the value of the backup insurance policy

[113] See, for instance, Eugene Steuerle and Jon Bakija. *Retooling Social Security for the 21st Century*. Washington: The Urban Institute, 1996.

(the chance that they will become eligible for assistance) is greater. Hence, while mandates common to social insurance may be harder to enforce at lower income levels, it is at those income levels that the greatest inequity exists between those with equal financial resources who purchase and do not purchase insurance.

As an example, economists would assert that employees with $20,000 in wage income and $5,000 in a health insurance policy from an employer essentially earn $25,000 in income, 20 percent of which goes to buy health insurance. If other employees earning $25,000 a year do not purchase health insurance, they may have a backup policy with an expected value of, say, $2,000, and they ride free on the contributions of those who do purchase insurance or pay taxes. This creates an equity problem known formally as "horizontal inequity," "unequal treatment of equals," or "unequal justice before the law."

Social insurance solutions recognize that these inequities must be tackled; at the same time, they may approach the progressivity issue separately by providing greater subsidies for those having less income.[114] Here, unlike the current health insurance system, concerns over horizontal equity are met through a system of mandates. The requirement that individuals buy automobile insurance or pay into a Social Security system are examples of how social insurance is used to deal with similar considerations of equity. Thus, motorists capable of buying insurance are not allowed to remain uninsured, thereby shifting costs onto others; nor are those with the ability to make contributions to a retirement system allowed simply to fall back on public support in old age without making contributions along the way.

[114] Social Security, for instance, was intended to be progressive. Even though annual benefits are higher for higher-income taxpayers, their annual taxes are higher still. Whether Social Security has achieved that goal (largely due to different mortality rates) is another matter.

With this social insurance setting, here then is the package of reform elements that might be put into a reform plan:

Summary of the Reform Package

- A simplified, moderate subsidy to purchase insurance, available for use in either the employer-provided or the individual market.
- The subsidy would be a flat dollar credit amount offered in lieu of the employee exclusion for employer-provided insurance, available to people at all income levels, whether taxable or not.
- The subsidy would not be meant simply to be a low-income subsidy but to replace existing middle-class and upper-income subsidies.
- An indirect mandate on individuals: if they do not obtain health insurance coverage, they would be denied the benefit of some subset of federal tax preferences such as the child credit, personal exemption, higher education subsidy, or itemizing deductions.
- Note that the poor generally would not be subject to the mandate since they do not pay federal income taxes; moreover, many are eligible for Medicaid.
- A fixed (but unindexed) cap on the value of employer-provided health insurance that can be excluded from taxation enforced through some liberal or simplified "safe harbor" rules for calculating whether the cap has been exceeded.
- As the cap becomes more restrictive (as health care costs escalate), more individuals and employers would move to the credit-based system; eventually the cap would become low enough that the exclusion of employer-provided health benefits would effectively be replaced by the credit.
- A requirement that employers (perhaps with some additional, front-end modest subsidy) at least offer health plans that employees could buy, and that the purchase cost of such plans be deducted from wages to the extent costs are paid directly by employees.

- A parallel requirement that any individual subsidy offered by the government would be reflected in wage withholding.
- An option for employers who provide insurance: insurance can be automatically provided and charged to the employee unless the employee formally opts out of coverage.

The Credit

Until more revenues can be raised, the size of the subsidy might need to start out small, say, an average of $1,000 per household (more for larger households, less for smaller ones, based on household size). To simplify and encourage coverage of children, I suggest not varying size of the credit by age. However, determining the credit on a per capita basis need not be a crucial element. I have suggested in the past that a credit-based system might first apply only to children, and then be expanded later to cover adults. If this were the case, then the mandates discussed below (removal of some tax preferences) would have to apply only to child-related preferences.[115]

While the cap on employer-provided insurance might raise only modest amounts of revenue at first, these added revenues would grow considerably over time, because the cap forestalls automatic growth in the annual cost of this exclusion, which, as currently structured, is estimated to grow by more than $50 billion after only five years. Extrapolating further shows yields over $100 billion annually after eight to 10 years. *This proposal suggests taking a significant share of that growth and converting it to a credit offered equally to all those insured*.[116]

The credit would be available for privately purchased health insurance, or insurance purchased through an employer with either employer or employee money.

The Mandate

Mandates on individuals to buy health coverage are not a new idea. The version I prefer is not a complete mandate, but one that relies on penalties that can reasonably be assessed. During the early 1990s, when President Clinton proposed health reform, mandates on employers were considered. This is the wrong locus for imposing a mandate, however; the logic of social insurance requires that the mandate be imposed on individuals. When placed on employers, the mandate does not apply to large segments of the population and operates more like a minimum wage requirement that could adversely affect employment.[117]

But this raises an additional set of issues. How can an individual mandate be enforced? I do not believe that a *complete* mandate to buy insurance can be enforced—the Achilles heel of many proposed reforms. After all, what would one do with scofflaws? Throw them in jail? In addition, the mandate must apply at many moderate-to-middle-income levels where some people buy insurance and others do not. At those income levels, there are often inadequate resources available to pay any large penalty, even if it were desirable to impose and possible for the Internal Revenue Service (IRS) to hire enough enforcement personnel. I am led to believe that the proper form of a mandate should be a simple penalty—eliminating the ability to benefit from some items of tax relief, such as a child credit, personal exemption, itemization of deductions, or educational tax benefits. (Indeed, re-

[115] See, for instance, C. Eugene Steuerle and Jason Juffras. "A $1,000 Tax Credit for Every Child: A Base of Reform for the Nation's Tax, Welfare, and Health Systems." Working paper prepared for the National Commission on Children, Changing Domestic Priorities Project, Urban Institute, April 1991, and C. Eugene Steuerle. "Beyond Paralysis in Health Policy: A Proposal to Focus on Children." *National Tax Journal* (September 1992): 357-68.

[116] Note that the increase in costs will not equal the revenues made available by a cap, since some share of the increased cost is caused by those policies whose costs grow, but which are still below the cap. Also note, however, that the tax expenditure budget ignores the tax subsidies provided through both Social Security taxes and state individual income taxes.

[117] See C. Eugene Steuerle. "Implementing Employer and Individual Mandates." *Health Affairs* (Spring 1994): 54-68, and Mark V. Pauly. "A Case for Employer-Enforced Individual Mandates." *Health Affairs* (Spring 1994): 21-33.

cent child credit expansions could have been designed in such a way as to lead to substantially increased health insurance coverage. An enhanced child credit might still be used for this purpose.)

Reduced public costs for covering the uninsured could be used to offset the loss of tax subsidies (such as the child credit). Moreover, the money raised by the mandate could be spent in the same income classes from which it came. In that way, any overall progressivity goal could be maintained. Or it could be spent on further subsidies to states to help low-income households obtain health care, in which case progressivity would be enhanced. The point, again, is that distributional (progressivity) issues could be resolved in ways that still recognize the importance of horizontal equity issues in social insurance (that people at equal levels of income or well-being have equal obligations).

The Cap

To help pay for this package of benefits, as well as to help reduce health care costs over time, there would be a cap on the value of employer-provided health insurance that would be tax-excluded.

One objection to this cap has often been that it is difficult to calculate the amount of benefits provided in excess of a cap. Accordingly, this cap would operate with some fairly liberal safe-harbor rules, such as a monthly limit of, say, $500 per employee with family coverage and $250 per employee with some form of individual coverage. The safe harbor might not require separate calculations even if employees choose from among different plans that in the end have different values (for example, if an employer provides $400 for half of employees' families and $550 for the other half, it would still comply with the $500 on average safe harbor). Employers operating within the spirit of the rule could also propose other safe harbors to those regulating the system. It is important to remember that the cap becomes tighter as health costs rise relative to its fixed nominal amount, while the value of the credit rises as the revenues from the tighter cap are shifted toward the credit-based subsidy. Slight inequities in the value of tax subsidies around the cap value are small compared to the current inequities between those who are subsidized for expensive insurance and those who get no subsidy at all.

To ease their own administrative responsibilities, employers likely would gravitate toward the type of plan operated for decades by the federal government. Under this plan, employees paid out of after-tax income for any cost of insurance above some limit. For instance, if they wanted the Blue Cross high-cost option, they might pay $100 extra a month, whereas if they accepted the Blue Cross low-cost option, they paid only $10. The $100 or $10 in this example was essentially taxable. The calculation was clean, straightforward, and easy to administer. No one complained about the administration or possible difference in value of insurance, which generally would be far more important than any small difference in the value of the tax break surrounding the insurance.

Flexible payment, cafeteria, and other plans offering individuals options to put aside money tax-free also would be restricted to ensure that the cap is not exceeded.

After a period of time, I expect employers would generally adopt a defined contribution approach to the purchase of health insurance since that fits in easily with a credit-based system. They might make employer contributions or rely on employee contributions or both, but the design and administration of contributions would resemble that of 401(k) retirement plans.

As the credit grows in value and the exclusion remains fixed, more employers would switch to the credit-based subsidy option. Thus, the cap would provide increased revenues that would be used for the credit (which might also be indexed at a minimum to grow

with inflation or, for awhile, with wages). Also, I expect that Congress might even periodically decide to bump up the value of the credit. As the credit grows, and the cap does not even keep up with inflation, more employees and employers will opt for the credit rather than the exclusion. Eventually, the exclusion itself might be eliminated.

As employees see more directly the net effect of health insurance purchases on their total compensation, they would also likely begin to push employers to offer lower-cost health plans. Many employers would likely see some advantage to making costs more explicit when the time comes to bargain with labor over total compensation packages. Retirement plans have been moving in this direction for some time, for similar reasons.

Engaging the Employer

A system with individually based credits that is badly designed could disrupt the market in which employees purchase insurance directly or indirectly from employers. Employer involvement eases administration and decision making for individuals, so it should continue to be encouraged—although not at the cost of discriminating against those who are not offered employer-based plans. Some advocates of individual credits have discounted or deprecated the value of employer participation. I do not. Indeed, I suggest that there are ways to build on and expand employer participation.

Accordingly, employers would be involved in this package of benefits in three different ways: (1) through a requirement to offer plans; (2) through tax withholding adjusted for both size of credit subsidy and withdrawal of some tax benefits for those who do not declare themselves insured; and (3) through an option whereby employees can be placed into a health insurance plan unless they opt out.

The Requirement to Offer Plans. All employers would be required to offer (but not necessarily pay for) coverage. Thus all employers, large or small, would eventually be involved directly or indirectly in encouraging their employees to purchase health insurance. An employer that is contributing to the coverage premium would have to decide between using the employee exclusion tax benefit and converting to the credit-based system. An employer that does not contribute to health coverage would still have to offer coverage, for which employees could claim the tax credits.

This health reform package avoids both mandating that employers buy insurance for their employees and limiting the credit to only employer-provided insurance. The proposal envisions an individually based system in terms of both mandates and subsidies. At the same time, it seeks to engage employers in implementing this system, taking advantage of their natural ability to organize, communicate with employees, and, if the employer is large enough, create a natural insurance pool.

There is substantial evidence in the field of retirement plans that individuals save much more when offerings are made through employers. For instance, although individual retirement accounts (IRAs) are freely available to most individuals, less than 10 percent of eligible individuals invest money into such accounts each year. Yet, when employers offer retirement plans, participation rates by individuals making their own deposits are much higher, often ranging from 30 percent to 80 percent (even when there is no employer match). Merely offering plans, I believe, will substantially reduce the numbers of uninsured. This requirement dovetails nicely with the requirement to reflect various individual subsidies and mandates in wage withholding, discussed next.

Withholding. The employer would administer both the credit subsidy and the mandate (a penalty for those who do not declare themselves insured) in the same way other taxes or contributions for United Way are administered. Note that this combined effect on incentives could be significant, even though the

subsidy and the mandate, each by itself, might only be modest.

Suppose, for instance, that the subsidy (the carrot) would reach $1,000 over time, and that the loss of other tax benefits for those who remain uninsured (the stick) would also be $1,000. Together, that provides a net incentive of $2,000 for an individual to buy an insurance policy for his or her family, a sum not obtainable if the reform were to use only carrots or only sticks. Approximately $170 a month would not be enough to purchase a good policy outright, but for many households it might cover more than half the cost of a policy with some basic protections, including catastrophic care and normal checkups.

Opting Out Rather than Opting In. The final point of employer involvement takes advantage of yet another facet of the employee benefit world. It turns out that participation in retirement plans appears to be much higher when employees are automatically enrolled unless they opt out, rather than requiring them to opt in. The same should be true in health care.

This reform package would not *require* employers to offer participation on an "opting out" basis, but I suspect that many might decide to do so. In addition to encouraging better insurance coverage for employees, the "opting out" strategy might make it easier to increase tax withholding on employees, because these employees could be asked to declare at the same time that they opt out whether they have coverage elsewhere for their families.

Minimizing the Administrative Burden on Employers

How can these requirements and options be designed to minimize administrative burdens placed on employers, especially small employers? To start, each employer could offer as many plans as it desired, but the requirement to offer any plan at all would apply only if at least one plan was available to the community and approved by the state. (States would have to face some trade-offs in deciding how comprehensive the plan must be, but some catastrophic element probably would be required in all cases.) The availability of a credit almost guarantees that over time different insurers would try to offer plans and would lobby the state to approve the plans. Meanwhile, the state would want to get the best health care value for its citizens and, thereby, would have an incentive to make sure some plan was offered, so as to garner federal money into the state. As with many elements of this package, it would take time for these developments to take place, and the small employer might not be able to offer a plan until the state made sure at least one was available. But the incentives of this reform structure likely would result in most employers of all sizes eventually offering plans.

Any changes in tax withholding would also be very simple. For proof of insurance, the employer could rely on evidence that an employee had accepted some health insurance plan the employer offered. For other health insurance, the employer could be allowed to rely on a statement by the employee that the employee and his or her family were insured. This means that compliance would depend on self-reporting by the individual, but the formal requirement to make a statement, with its perjury implications, often goes a long way toward minimizing cheating. The employer's primary burden would be to approach those not insured through an employer-provided plan periodically—say, twice a year—perhaps at the same time that employees are approached with the option to buy into an employer-offered plan. This periodic questioning of employees would reinforce the need to buy insurance and the personal cost of not doing so—as much as it would help to make withholding more accurate.

Since the credit amount would not phase out with income, its exact value each month would be known in advance. The withholding

would be easy and exact. As for the penalty, it would use the same formulas that already are implicit in tax withholding schedules for number of dependents and so forth. The IRS would provide the same type of alternative look-up schedules already used by employers. Depending on the exact nature of the mandate adopted, the change in withholding might entail nothing more than changing to zero the number of personal exemptions and child credits that could be claimed.

The final point of employer involvement entails an option to enroll employees automatically unless they specifically ask to be excluded (and indicate that they have insurance elsewhere to ensure correct withholding). There would be no additional requirement on employers at all, and the administration of this option likely would not be any more difficult than the opposite approach, whereby employees elect into (rather than out of) an employer-based health insurance system. In any case, there is no extra administrative burden unless the employer chooses to use this particular system.

Back to First Base: How the Package Approaches the Dilemmas and Constraints

With this package, I would take money that actually contributes to a decline over time in health insurance coverage (because of its effects on rising costs) and redirect it in a way that should expand coverage. Moreover, this plan reallocates the money in a more progressive manner. At the same time, I have tried to make costs and benefits explicit to improve the decisions about future health care. Thus, I believe that as the credit and mandate system takes hold, and employers move toward a defined-contribution approach, often combined with a fixed-dollar premium contribution per employee, the costs of insurance would be made much more explicit. And as those costs are made explicit, workers would grasp more completely how much they are willing to pay for insurance, or get in employer benefits, relative to the cash wages they receive. Moreover, with a capped subsidy and recognized costs above the subsidy, individuals would have a significant incentive to bargain to add features to plans that limit costs over time. The improved market for health insurance, in turn, would reduce health costs for everyone over time, thus leading to increased insurance coverage (or lower rates of drop-out from private coverage). In a sense, this part of the plan is a variation on the "managed competition" approach to health reform, but one that recognizes that the main goal is to get the incentives lined up correctly, not to pick some one-size-fits-all approach such as managed care, preferred provider organizations, or system with larger co-payment rates.

At this point, it is worth stepping back and asking how well this package addresses the dilemmas posed at the beginning of this essay. In my view, all reform plans—as well as current law—should be forced to run this gauntlet to see how they stack up against each other. Let me be clear. There are costs associated in any approach to resolving a dilemma; that is why it is a dilemma. This package expands health insurance coverage at zero cost (or modest cost, depending on size of the subsidy) to the government, but it does not solve the problem of providing universal health care, nor does it avoid all adverse selection. Along with expanded coverage, therefore, the package seeks to provide a viable way of improving significantly the existing market at a reasonable cost.

The Budget. A share of the existing resources spent on health care would be frozen and then re-spent on a gradually improving set of options for individual purchase of health care. Over time, Congress could add to the subsidy side of the ledger, but by discretionarily increasing the value of the credit as opposed to automatically increasing the value of an inefficient exclusion that is becoming

more regressive over time. Here, I have concentrated on restrictions on the employee exclusion of employer-provided health care, but I believe this type of budgetary model can also be extended to areas like Medicare in ways that induce more cost consciousness and help to increase insurance coverage. But that is another subject. Paying for some or most changes, as well as improving the incentive structure to reduce costs over time, would go a long way toward resolving the budget dilemma.

Average Health Care Spending. In applying restrictions on the existing subsidy, employers would calculate under various alternatives the cost of the health insurance they provide. More and more these costs would be stated explicitly on the health policy itself, and purchases of insurance above some cap would be recognized explicitly as coming from after-tax income. Eventually the system would convert to one for which accounting is done on a contribution basis where employees see fairly explicitly the value of the government subsidy, the value of the employer payment, and the total cost of the insurance. They would gradually come to recognize their costs, both in out-of-pocket payments for insurance and in reduced cash wages. They would start making decisions that could lead to a health insurance system that provides both lower growth in average health care costs and better health care per dollar spent on insurance.

Infinite Demand at Zero Price. The credit amount offered to most middle-income taxpayers would not be sufficient to cover the cost of health insurance. However, since it applies only to the first dollars of insurance purchased, at least the price of additional insurance becomes more explicitly recognized. To cover costs not met by the subsidy, I would expect that plans would make even greater efforts to offer better coverage at lower cost through a variety of techniques. These include the use of co-payments that force the purchaser to bear some of the cost of various decisions, such as whether to purchase generic drugs, and still newer approaches to preferred-provider and health-maintenance types of options. Such options, I believe, would expand simply as a matter of economics, despite their disagreeable aspects that relate directly to making costs explicit. Nonetheless, the reform package suggested here does not entail specifying how they will evolve; new market experiments are continually required.[118] At the same time, the reform plan does not anticipate stopping individuals from buying wrap-around policies, nor does it attempt to regulate such efforts.

Bang per Buck per Incremental Expansion. The expansion in health insurance coverage is done in a way that entails little or no net increase in government health costs. That is, much or all of the expansion would be paid for through a cap on the existing exclusion, through a credit to many who do not now receive any subsidy, through some redistribution of subsidies from higher- to moderate- and middle-income households, and through the tax penalties imposed on those who fail to comply with the mandate. Moreover, the growth rate in costs likely would fall over time with greater consumer awareness of those costs. Even if the subsidy or credit amount is greater than what can be financed through other cutbacks—that is, if some new budget outlays would be required—I still expect a remarkable improvement over current law and most other reform options. One reason is that a variety of cost-improvement mechanisms are built into the policies, including the cap on tax-free employer-provided benefits and the movement toward a defined contribution system where people see

[118] Uwe Reinhardt recently demonstrated that chronic activity is inherent in health reform since payers and providers view each other with permanent suspicion. One implication, I believe, is that reform has to be developed in a way that channels this activity, rather than seeks some permanent solution to an ever-evolving health marketplace. See Uwe E. Reinhardt, "Churchill's Dictum and the Next New Thing in American Health Care," Business Economics (July 2003): pp. 38-52.

and bear more fully the full cost of health insurance expansions. Over time these not only should lower the cost of insurance from what it would otherwise be, but in the process, help to expand the numbers of those who can afford to buy health insurance. Of course, the tax penalty imposed on middle-income taxpayers who do not purchase health insurance also would raise revenues that could be used for health insurance expansion at no budgetary costs.

Who Should Be Subsidized? Who Should Pay? This proposal produces parity among taxpayers with roughly equal incomes. No one would be penalized with denial of a credit simply because he or she had already purchased health insurance. Of course, adherence to the equal justice principle also meant that no attempt was made to allow the government to offer some new subsidy only to those who don't have health insurance. At the same time, the penalty for not purchasing health insurance would improve horizontal equity over current law.

Economic Growth and Productivity of the Health Sector. The proposal leaves a wide range of decisions to individuals or to intermediaries such as firms operating on their behalf. This decision-making is especially important for growth to occur in an evolving market where the basket of goods and services offered over time is going to change rapidly in ways that cannot be foreseen or controlled by some government bureaucracy.

Engaging the Market and Adverse Selection. Again, the proposal relies heavily on individual decision making and recognition of the cost of insurance as a way of improving the market for health care. That does not mean that adverse selection cannot become an issue. I believe, however, that it is a mistake to try to write some one-size-and-time-fits-all regulation to try to limit such selection. States would retain some flexibility in what they offer in the way of assistance, and the credit could be restricted to plans covering some minimum number of individuals (thus, effectively creating some minimal amount of "community rating"). However, many employers operate in many states, and individuals cross state lines all the time. Therefore, I do not want to impose multiple levels of state regulation that may be difficult to administer and enforce across state boundaries.

The Welfare Dilemma. Partly for administrative reasons, the credit suggested here does not phase out with income. Thus, there is no new implicit tax system created and no notches where one suddenly loses all benefits. Moreover, to the extent that people now face a notch in Medicaid, it will be smaller, as they will immediately be eligible for the credit when they earn one more dollar and lose their Medicaid. As noted, Medicaid itself could be reformed to take advantage of this credit base, although I have not dealt with that issue here.

Conclusion

Through careful design, it is possible to expand health insurance coverage at little net cost to government. A social insurance approach to health insurance reform is superior in many ways to a welfare approach, because the former explicitly de-couples the issues of who should be subsidized with who has some obligation to pay for benefits received. Thus, the social insurance approach works separately but simultaneously on both the subsidy issue and the mandate or requirement to buy insurance. The credit-based subsidy proposed here creates better incentives to buy insurance and is more progressive than the employee exclusion that grows increasingly regressive over time. At the same time, any mandates arising out of a social insurance scheme should be imposed on individuals, not employers, and they should be practical and easy to administer. The proposal suggested here adopts a partial mandate because of practicality constraints, but it will also expand insurance coverage and improve equity between

those who do and do not purchase insurance. Finally, health insurance coverage can be expanded by taking advantage of employer involvement in offering employee benefits, including what we have learned about how to increase participation in employer-sponsored, defined contribution, retirement plans.

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Steuerle

Key Elements

C. Eugene Steuerle has developed an incremental coverage expansion proposal that is designed to mitigate perverse incentives in the present system that discourage cost consciousness and encourage ever-larger private and public spending for health coverage—spending that is often not directed to areas of greatest need or to improving quality of care. The proposal includes the following elements:

THE PROVISION OF THE TAX CODE that allows employees to not pay tax on employer-paid health insurance premiums would be changed: the exclusion would be capped at a fixed-dollar amount, which would not change over time as health insurance premiums increase.

PEOPLE AT ALL INCOME LEVELS could choose to take advantage of a modest tax credit as an alternative to the tax exclusion; the size of tax credit would increase over time.

EMPLOYERS WOULD BE REQUIRED TO OFFER, but not necessarily pay for, at least one state-approved health insurance plan for employees.

AN "INDIRECT" MANDATE WOULD BE ESTABLISHED and enforced through the federal tax system: individuals who failed to get coverage would lose some tax benefit, such as the personal exemption, credits to help pay higher education expenses, etc.

THE INITIAL SOURCES OF FINANCING for the tax credit would be tax revenues from the portion of employer-paid premiums that are newly taxable and the tax penalties imposed on people who fail to arrange coverage.

EMPLOYERS WHO OFFER COVERAGE would be encouraged to adopt the practice of automatically enrolling employees in the employer's health plan unless they specifically chose to opt out.

About the Author

C. EUGENE STEUERLE, PH.D., is a Senior Fellow at The Urban Institute and co-director of the Urban-Brookings Tax Policy Center. He is the author, co-author, editor, or co-editor of ten books, and over 150 reports and articles, 600 columns, and 50 Congressional testimonies or reports. Among many other positions, he has served as Deputy Assistant Secretary of the Treasury for Tax Analysis, President of the National Tax Association (2001 to 2002), chair of the 1999 Technical Panel advising Social Security on its methods and assumptions, President of the National Economists Club Educational Foundation, and Resident Fellow at the American Enterprise Institute. Between 1984 and 1986 he served as Economic Coordinator and original organizer of the Treasury's tax reform effort, for which Treasury and White House officials have written that tax reform "would not have moved forward without your early leadership" and the "Presidential decision to double the personal exemption...[is] due to your insightful analysis." Dr. Steuerle has published articles on such issues as the financing of health care, the use of mandates, and the economic effect of health insurance subsidies. He has provided Congress with testimony and served as faculty at health reform retreats by both the Senate Finance Committee and the House Ways and Means Committee. He has promoted health reform proposals to focus on children and to provide both “carrots and sticks” to encourage the purchase of health insurance.