Reforming the Tax Treatment of Health Care to Achieve Universal Coverage

by Stuart M. Butler

Overview

The aim of this proposal is near-universal health insurance for working households, including the self-employed,using a tax-based subsidy and insurance reform to make such insurance affordable. Virtually all legal residents would be included in the proposed system (other than those enrolled in government programs), including those who currently have employer-sponsored health insurance. The place of employment would continue to be the point at which subsidies typically are delivered and choices made for most working people, but employers would no longer have to sponsor plans for employees to receive a tax subsidy. The proposal envisions a range of other organizations, from churches to unions, that would supplement traditional employer-sponsored health insurance by sponsoring health plans in tandem with an insurer that carries the insurance risk. Self-employed individuals or those temporarily out of the workforce, and employees of firms that do not sponsor insurance, could use the tax benefit to enroll in plans offered by such organizations or by health insurers.

In the proposed system the tax exclusion for employer-provided health insurance and other health care tax benefits currently available would be replaced with a new refundable tax credit based on income and household health costs (both insurance premiums and out-of-pocket costs). The design of the tax credit would provide greater assistance to lower-income families and less assistance to higher-income families than today's system of tax relief. It would also give much more assistance to those households that face unusually high medical costs, regardless of their income.

The proposal would achieve horizontal equity: Households with the same income and medical expenses would receive the same tax benefit, whether they obtained coverage through their employer or another organization, or they purchased their own insurance and care. Low-income households could choose between two forms of tax benefit: a refundable sliding-scale tax credit based on total health expenditures as a proportion of family income, or a flat credit that,if desired, could be assigned to a chosen health plan in return for a reduced premium. Households above a specific income threshold could use only the sliding-scale credit. The federal credits could be supplemented with state subsidies, and the federal government would encourage state subsidies through a new federal grant to states.

Money for the new system of tax credits would come from two sources: elimination of the existing tax exclusion and other health tax breaks and general tax revenues. Americans generally are resistant to sweeping change, so the proposal envisions a gradual transformation of the tax treatment of health care costs, beginning with the introduction of limited refundable tax credits for those without employer-sponsored coverage or who are unable to afford it. Thereafter, the tax exclusion would be reduced gradually, in line with the general availability of a more comprehensive system of tax credits (available for out-of-pocket medical costs, health savings accounts, and insurance).

Employers would be required to modify their federal tax withholding procedures to reflect each employee's estimate of the health credit available to him or her. Employers would also be required to set up an escrow account to make payments, deducted from employee compensation, to any plan chosen

by the employee that met the minimum government requirement. Working families would have to enroll in at least a minimum, catastrophic health insurance plan to be eligible for the tax credit for any health costs. They could choose any approved plan in the area, unless their employer sponsored a plan, in which case they would have to join it to obtain tax relief. If an employee did not choose a plan,he or she would be enrolled in a default plan or program determined by the state.

The federal government would establish a "default" system of health insurance regulation to encourage the availability of affordable insurance that could be purchased with the credit. The default system would include modified community rating for all plans with federally approved minimum benefits,and a change in federal law to create new forms of group insurance plans.States could choose either to adopt the federal default or to agree with the federal government on a functionally similar state-designed rate regulation system. In addition, each state and the federal government would have to agree on a plan to eliminate uninsurance. The proposal envisions a market in which families obtain insurance from organizations with which they are affiliated, such as unions, churches, and similar groups; from their employer if that employer decides to sponsor coverage; from large insurers or managed care plans; or from health plans sponsored by large employers and offered to non-employees.

Coverage and Eligibility

Today's tax code provides a number of tax benefits for health care intended to help working families to obtain health care coverage. But the current system places severe limits on who can obtain tax help.[1] By far the largest form of assistance is the exclusion from an employee's income of employer-paid health insurance benefits. The value of all health care tax benefits (including reductions in payroll and income taxes) has been estimated for 1998 at $111.2 billion at the federal level and $13.6 billion at the state level.[2] The design of the exclusion has been widely criticized as a highly inefficient and inequitable method of helping working families to afford health care.[3] Since the exclusion is for insurance only, it also leaves lower-income employees vulnerable to high out-of-pocket expenses without any tax relief.[4] And because the exclusion is only for employer-sponsored coverage, employees of firms without a health plan cannot claim the tax benefit if they pay for their own plan.[5]

The proposal would fundamentally change this tax treatment,using the tax code to direct assistance in a far more equitable and progressive way. It would create a tax subsidy system available to all working households of legal U.S. residents (other than Medicaid and Medicare enrollees, and those normally enrolled in state-sponsored programs). The tax exclusion available to employees for employer contributions to their health care plan or expenses would be repealed, as would other health care tax deductions available to taxpayers, and replaced with a fully refundable tax credit available to all individuals for health insurance and out-of pocket medical expenses.[6] The credit could be used to help pay the employee cost of employer-sponsored benefits. Employers would continue to deduct health payments as a cost of labor. All individuals

[1] For a discussion of the tax treatment of health care, see Grace-Marie Arnett (ed.). *Empowering Health Care Consumers through Tax Reform.* Ann Arbor, MI: University of Michigan, 1999.

[2] John Sheils and Paul Hogan. "Cost of Tax-Exempt Health Benefits in 1998." *Health Affairs 18* (2): 178.

[3] Sheils and Hogan estimate the average value of all federal health tax benefits for 1998 at $296 for families with incomes of $15,000 to $19,999 and $2,357 for families with incomes of $100,000 or more (Sheils and Hogan, p. 180). Although these averages exaggerate the differential between lower- and upper-income families with employer-sponsored insurance (since a higher proportion of lower-income families receive no tax benefits), the combination of lower-cost plans and a lower tax bracket means a large inequity for insured families. Workers without employer-sponsored insurance typically receive no tax benefits unless they are self-employed.

[4] Many employers do offer tax-free Section 125 accounts that reduce this problem. But Section 125 requires employees to agree to a payroll deduction to fund the accounts, and unused balances in the accounts revert to the employer at year's end. This discourages most employees from using the accounts to shield from taxation all but the most predictable out-of-pocket expenses.

[5] Taxpayers can claim a tax deduction for unreimbursed health expenses, but the taxpayer must itemize deductions and can deduct only amounts that exceed 7.5 percent of income.

[6] In the proposal, fully refundable means the individual or family would be eligible for a subsidy from the federal government if the computed credit exceeded the family's federal income and payroll tax liability.

currently receiving tax relief for employer-sponsored plans would be eligible for the credit,as would those working families without access to employer-sponsored coverage. Thus there would be no eligibility distinction among those receiving tax relief for health care. As noted in the discussion below regarding administration of the program, there would be mechanisms to deliver the credit to those who are moving between jobs or are unemployed.

To receive the tax credit,the individual or family would have to purchase a health insurance plan that included at least certain minimum benefits. With the refundable tax subsidy available to all those not currently in a government program, along with a grant program for states to supplement the federal credit and a federal-state compact to make affordable group insurance more available (discussed below), the proposal would achieve near universal coverage.

Structure of the New Subsidy

Lower-income households would have a choice between two forms of tax credit—a fixed credit and a sliding-scale credit. Other households would be able to claim a sliding-scale credit.

Fixed Credit

Low-income families could claim a fixed credit for health care expenses, provided the family obtained at least the minimum insurance coverage. Eligible expenses would include insurance, direct spending on services, the employee cost of employer-sponsored plans,and contributions to accounts intended to cover health costs, such as medical savings accounts and employment-based flexible spending accounts. The credit would be $1,000 per adult and $500 per child, up to a maximum of $2,500 per family. This fixed-credit option would be available to families with incomes of up to $20,000, and to singles with incomes up to $12,000. There would be no phase-out for this credit.

The fixed-credit option offers simple and predictable assistance for lower-income working families,although in most cases the family would receive more assistance by choosing the sliding-scale credit. It would be available only for families below certain income thresholds. The reason for this is that a fixed credit for all households would exceed the value of the sliding-scale credit and the value of today's exclusion for most upper-income families, while the purpose of this approach is to concentrate health tax benefits on those families facing the greatest difficulty in affording health care.

An individual or family eligible for the fixed tax credit could choose to assign it to a chosen health plan in return for a commensurate premium reduction. In this case the insurance company would adjust its own tax payments to the federal government to reflect the fixed-credit amount, while for tax purposes the enrollee would be deemed to have received the credit. This could be arranged through the workplace, as noted below, or directly with the health plan for self-employed or temporarily unemployed individuals.

Of course, many families would not be certain whether their income would be below the thresholds for the fixed credit, but this is less of a practical concern than it might at first appear. As explained below, the place of employment normally would be the means through which plan choices, payments, and tax benefits would be channeled. The employer would inform the employee whether the basic wages or salary of the employee would make his or her family eligible for a fixed credit. If the employee discovered during the year that his or her income exceeds the threshold and so becomes ineligible for the fixed credit (because of a salary increase or overtime pay, for example), the employee would not actually have to cancel the assigned credit with his or her health plan, but simply factor the amount into his or her adjusted withholdings or end-of-year tax return. In a few cases, some particular workers with rising incomes might receive slightly too much money under the fixed credit. But requiring individuals who just exceed the eligible threshold to calculate a sliding scale and return the difference would not be worthwhile. It is not necessary for advance payments made through the tax code to be reconciled perfectly at the end of the tax year, only that they be reasonably close (as a comparison, the standard deduction is a loose reconciliation that may

shortchange the taxpayer or the IRS occasionally, but has the advantage of simplicity).[7]

The Sliding-Scale Credit

Both high- and low-income households would have the option to claim a fully refundable sliding-scale credit based on health expenses as a proportion of total income.[8] Different families would qualify for a different credit amount for a year's health costs, depending on their incomes, much like the child care credit in the tax code. Expenses eligible for the credit would be the same as in the fixed-credit option. As in that option, health expenses would include premium costs and out-of-pocket expenses. It would be calculated as follows, subject to a maximum credit of $12,000 per year for families and $5,000 for individuals:[9]

Structure of the Sliding-Scale Credit Option

Health costs up to 5% of adjusted gross income (AGI)	25% credit
Health costs between 5% and 15% of AGI	40% credit
Health costs above 15% of AGI	60% credit

An income-related sliding-scale option would be more complicated than the fixed-credit option (although many families use such a sliding-scale credit for the cost of child care), but it typically would mean a larger subsidy, especially for those whose high costs accounted for a large proportion of their income. It can also be designed to avoid major tax changes for middle-income Americans who would lose their current tax exclusion. In addition, the sliding-scale credit provides some age and geographic adjustment, because families in areas with relatively high insurance and medical service costs—or other workers facing higher costs—would be able to claim a larger federal credit. The dollar value of the credit also would rise over time in proportion to medical costs. Moreover, for many families, the credit could be estimated very accurately, because heavy medical expenses are not necessarily unpredictable. For instance, a family with chronic medical problems may pay the full stop-loss amount routinely each year and be able to project its out-of-pocket costs.

Families below the income thresholds for the fixed credit would have the option of claiming whichever credit provided them with the most money. Those above the thresholds could claim the sliding-scale credit only. The thresholds are calculated to be just below the "break even" point for the great majority of families,meaning that the value of the fixed credit at the thresholds typically would be only slightly less than the value of claiming the sliding-scale credit. In most instances this avoids a sharp "cliff effect," in which a small rise in income means a large drop in the value of the credit.

State Subsidies

The tax credit proposal is designed to be as compatible as possible with existing state programs, such as Medicaid, the State Children's Health Insurance Program (S-CHIP), and high-risk pools. It is not designed to replace them.

New Federal Grant

Under this proposal, the federal government would provide $6 billion annually to the states to assist them in supplementing the federal tax credit for health-related expenses. In addition, each state

[7] For a brief discussion of the tax reconciliation issue, see Linda J. Blumberg. "Expanding Insurance Coverage: Are Tax Credits the Right Tack to Take?" Unpublished paper, The Urban Institute, Washington, DC, August 12, 1999, p. 18.

[8] The design of the proposed credit follows consideration and evaluation of a number of tax credit proposals, including various fixed-credit and percentage-credit as well as earlier sliding-scale credit proposals by the author and his colleagues at The Heritage Foundation (one of which formed the basis of legislation, S 1743, HR 3698, introduced in 1993 by Sen. Don Nickles [R-OK] and Sen. Cliff Stearns [R-FL]). See Stuart Butler. "A Tax Reform Strategy to Deal with the Uninsured." *Journal of the American Medical Association 265* (19) (May 15, 1991); Stuart Butler and Edmund Haislmaier. "The Consumer Choice Health Security Act." *Issue Bulletin* 186, December 1993; Stuart Butler. *Expanding Health Insurance through Tax Reform.* Menlo Park, CA: The Henry J. Kaiser Family Foundation, Kaiser Project on Incremental Health Reform, October 1999. A combined fixed credit/sliding-scale credit similar to the current proposal was introduced in July 2000 (HR 4925) by Rep. John Cooksey (R-LA).

[9] A limit is placed on the credit on the assumption that families facing extremely high health costs are helped best by a combination of a federal credit and other means, rather than solely by a formula credit.

would receive a grant amounting to the estimated federal taxes raised in the state from individuals who do not enroll in a minimum health plan and thus cannot claim the federal credit.

State supplements would be especially important for low-income workers, such as most of those currently leaving welfare,and, when combined with the federal credit, could enable the worker to afford a reasonable level of health insurance. States are required by the 1996 welfare reform legislation to provide Medicaid coverage to certain families even though they do not receive cash assistance, and many states also take advantage of the flexibility under the legislation to continue Medicaid coverage for other working families. But 1997 data indicated that about 40 percent of women who had left welfare since 1995 were uninsured.[10] The federal credit, especially if combined with state assistance, would provide significant assistance to these low-income families, increasing their potential to afford the out-of-pocket cost of employer-sponsored insurance,if offered, or to purchase other coverage and services. With the federal credit and grant available, states would have greater flexibility to design the best option to deal with various groups of working families, such as combining the federal credit with S-CHIP or other subsidies, and taking steps to make insurance less expensive for workers with the tax credit.

Financing

While a simulation of the proposal has not been undertaken, analyses of other similar proposals reveal its potential impact on government and household finances and on coverage.

Effect on Government Finances

THE FEDERAL GOVERNMENT

According to estimates by the Lewin Group, eliminating various health care deductions and the tax exclusion for employer-provided insurance would have led to an increase in federal tax revenues in 2000 of $116.1 billion[11] and a projected $130.4 billion in 2001.[12] Of this, approximately one-third would be extra payroll tax revenue ($31.9 billion in Social Security tax and $8.8 billion in Medicare Hospital Insurance tax in 2000).

While the state grant in the proposal would be a discretionary spending item, the federal credit would be a tax entitlement and not subject to the budget limitations that apply to discretionary programs. In other words, Congress would not have to vote for a specific budget amount each year for the credit. The net cost of the tax reform and new grant is envisioned to be between $40 billion and $50 billion annually.

IMPLICATIONS FOR SOCIAL SECURITY AND MEDICARE TRUST FUNDS

Approximately one-third of the tax revenue from the increase in taxable compensation resulting from the reform would be in the form of Social Security and Medicare taxes, and would not be available to fund a new health care credit. On the other hand, because this earmarked money would go into the retirement trust funds, there would be a reduction in the future amount of general revenue support needed to fund future retirement benefits. Thus, the equivalent amount of future general revenue could be allocated to help fund the tax credit.

STATES

State finances would be affected by the proposal in four ways.First, those states with an income tax mirroring the federal code initially would realize a windfall increase in tax revenues, assuming they did not change their tax rules. The proposal assumes this money is returned to state taxpayers. Second, by reducing uninsurance, the new federal credit would substantially reduce the burden on states of subsidizing hospitals and physicians for uncompensated

[10] Bowen Garrett and John Holahan. "Health Insurance Coverage after Welfare." *Health Affairs 19,* (January-February 2000): 177.

[11] John Sheils, Paul Hogan, and Randall Haught. *Health Insurance and Taxes.* Washington: The National Coalition on Health Care, 1999, p. 47. This figure assumes that employer contributions to employee retirement health plans remain tax-free.

[12] Letter from John Sheils, the Lewin Group, to Robert Moffit, The Heritage Foundation, dated July 6, 2000, assessing the impact of legislation (HR 4925) sponsored by Rep. John Cooksey.

The proposed tax credit structure is designed, on average, to leave most middle-income families with little change in their tax liability.

care. Currently Medicare and Medicaid disproportionate share hospital (DSH) payments amount to approximately $16 billion, so if the federal program were not reduced, the states would have a windfall gain. Third, each state would receive a grant based on the federal government's estimated savings due to individuals in the state who do not obtain the minimum basic insurance and thus cannot claim the federal credit. And fourth, the federal government would provide states with a total of $6 billion to supplement the federal credit and reduce uninsurance.

HOUSEHOLDS

The objective of the tax credit proposal is to make a reasonable level of health care insurance and services affordable to all working households without incurring strong opposition because of a large increase in the explicit tax liability of any other income group. Under the proposal, the net income of a family *after taxes and health expenses* would be affected by four factors. First, the family's taxable compensation would rise according to the size (if any) of the employer contribution to the worker's health plan. Second, the family's tax bill initially would rise because of this increase in taxable compensation. Third, the family might increase or decrease its health care expenses, depending on its preferences and whether it could cash out the employer contribution. And fourth, the family would qualify for one or both of the refundable tax credit options. The bottom line for the family would be the net effect of these four factors.

The proposed tax credit structure is designed, on average, to leave most middle-income families with little change in their tax liability. Upper-income households with high medical expenses also would not see a major change in their taxes. And many of those households that would pay significantly higher taxes would do so because they took more of their compensation in cash rather than health benefits—receiving, in effect, a pay raise. Lower-income families would be as much as $2,500 better off in federal tax benefits even if they decided to opt for the simple flat credit. But lower-income families with above-average total medical expenses could receive a larger amount of tax assistance through the refundable sliding-scale credit. For example, a family of four with $20,000 in income and $7,000 in health spending in any one year would qualify for a federal credit of approximately $3,500. But this family also would qualify for supplementary assistance financed by the federal grant to states as well as any other assistance the state provided.

Administration of the Program: A New Role for Employers

The place of employment is a particularly convenient and efficient venue through which to make insurance payments and handle other transactions (such as collecting federal taxes). The proposal envisions employers as the key clearinghouse for plan choices, tax adjustments, and payments associated with health care. But, unlike today, it would not require employers to organize or sponsor a plan, or make any contribution to the cost of coverage, for the employee to obtain tax relief. As noted below, for those heads of household who do not work for an employer, such as the self-employed and those between jobs, other mechanisms would apply for receiving credits and paying premiums.

Unless the employer sponsored a plan, employees would choose their own plans, and could change jobs without changing plans. Moreover, the tax benefits would no longer depend on insurance decisions made by the employer.

All employers would be required to undertake two key functions—delivering the tax credit to workers and paying premiums through payroll deduction.

Delivering the Tax Credit to Workers

Employers would be required to inform the Internal Revenue Service (IRS) and the state which health plan (or state-sponsored program) each employee had selected, and to adjust the employee's tax withholding to reflect the estimated value of the credit. This employment-based selection and financing mechanism has been suggested by a number of analysts.[13]

Withholding adjustments is the simplest way for most workers to obtain a tax benefit prorated each pay period,so they would not have to wait until the end of the tax year to receive their subsidy. For employees who elect to have their credit assigned to a health plan in return for a reduced premium, the tax withholding would reflect receipt of the credit. Since assignment would necessitate informing the IRS (via the employer) of the employee's choice,the agency could decide whether to audit an individual who did not file a tax return. The great majority of households that do not have to file a return would fall under the maximum incomes eligible for claiming the fixed credit.

It should be noted that all employed Americans (other than those in public programs) would be in the tax/premium withholding system. Thus, there would be no obvious distinction between upper-income workers receiving a small credit, and lower-paid workers receiving more assistance through a refundable credit. Only the withholding amount would vary, as it does for employees today. This system would mean no separate arrangements or stigma associated with the program.

Paying Premiums through Payroll Deductions

The second legal obligation on employers would be to institute an automatic payroll deduction system for health insurance premium payments, structured much like the flexible spending plans many employers now maintain voluntarily. Once the employee selects a health plan and indicates the employer's premium cost, the employer would be required to deduct a specific amount each pay period and place that amount in an escrow account. The amount would have to be enough to pay the premium, but also could include additional amounts, as today, to pay predictable out-of-pocket costs.[14] Since the eligible tax credit also would be made available at each pay period, the employee would have the necessary subsidy available for the payroll deduction. If the employee did not select a plan voluntarily, the employer would assign that employee to a default plan or government program selected by the state and make a default payroll deduction accordingly. Selecting a default plan or program,as noted below, would be part of an agreement between the state and the federal government to achieve maximum coverage.

The employer would be responsible for providing new employees with information from the government explaining the tax credit and payroll deduction system.Employees would have to sign a document stating they understood the system and indicating the plan in which they wished to participate. If they did not do so, the default plan assignment and payroll deduction would go into effect until the employer received information that the worker was enrolled in a state health plan or in an insurance plan elsewhere (such as in a spouse's plan).

There is good reason to believe that this mechanism would be efficient administratively and would lead to a high level of employee enrollment. Lynn Etheredge has proposed automatic workplace enrollment for a tax credit system and estimates that the administrative cost of insurance using such a system could be 7.5 percent, compared with administrative costs several times that for individual and non-employment small groups.[15] In addition, evidence from savings plans suggests that an automatic enrollment system for health insurance could have dramatic effects on sign-up rates. Brigitte Madrian and Dennis Shea have found that a workplace-based

[13] For example, see Lynn Etheredge. *Tax Credits for Uninsured Workers.* Paper prepared for the Health Insurance Reform Project of George Washington University, September 1999.

[14] Employers would not be required to accept amounts for out-of-pocket costs, though employers currently offering flexible spending accounts probably would do so.

[15] Etheredge, 1999, p. 6.

automatic enrollment system for 401(k) plans—where, to be excluded, the employee must actively decline to be included—boosted participation rates from 37 percent to 86 percent for such voluntary pensions, with even sharper rises for young and lower-paid employees (for employees with incomes below $20,000, the rate increased from 12.5 percent to 79.5 percent).[16] In the health system proposed here, of course, individuals not actively making a choice would be assigned a plan or enrolled in a state health program.

This payment system is also very similar to the way in which the Federal Employees Health Benefits Program (FEHBP) enables a federal worker who may work in a small office, such as that of a member of Congress, to choose from dozens of plans. In the FEHBP, the worker tells the employer which plan he or she has chosen, but the payment details are handled by the Office of Personnel Management (OPM), which for this purpose functions like a payroll processing firm for the individual's immediate employer. OPM functions as a clearinghouse, deducting premiums from each federal employee, pooling the money, and making payments to each health plan based on the total number of its government enrollees.

Estimating the Cash Value of Employer-Paid Health Benefits

Employer contributions to the employee's health plan would be considered taxable income in the first instance, but also would be considered employee expenditures on health for purposes of calculating the credit. This raises the question of how to calculate the per capita value of a group health plan for tax purposes. While this cannot be done perfectly—and, of course, the current system hides large tax benefit inequities—it can be accomplished accurately enough in one of two ways adopted in the 1993 Nickles-Stearns legislation. One option is for firms to negotiate the cash value with their employees. This probably would be the preferred option in unionized firms with a benefits contract or where an employer makes a defined contribution to an employee's health plan. If the firm and its employees did not choose this option, a fallback formula could be developed by the state or federal government. The best such formula might be a structure of relative values for various categories of household composition and risk (such as family structure, sex, age, etc.) that matches the categories used in underwriting restrictions placed on plan premiums by the federal government (for plans covered by the Employee Retirement Income Security Act, or ERISA) or state governments (for plans regulated by the state). In this way the assessed value for categories of workers would reflect the relative premium costs of coverage for these risk categories in the state.

This same method of calculation would be used when a firm and its employees chose to end a sponsored health plan in favor of turning that fringe benefit into cash income that employees could use to enroll in other plans. A temporary "maintenance of effort" requirement could be applied, so that in the first year after ending a plan the employer would be required by law to add the plan's value to paychecks, making the full compensation amount explicit as the basis for future pay levels.

If an employee had chosen to be enrolled in family coverage obtained by a spouse working for another firm, and thus did not receive an employer contribution and was not part of the employer's insurance group, there would be no taxable employer contribution. As today, it would be up to the employee (or his or her union) and the employer to decide if these employees received a taxable supplement to income in lieu of the contribution. If the firm and its employees chose to dismantle their existing plan to permit employees to choose other plans, the cash-out value for workers would be calculated the same way.

Employer-Sponsored Plans

This proposal envisions that those employers that wish to sponsor insurance themselves (arranging plans for their employees or self-insuring under ERISA) could continue to do so. If a firm decided to do that, its employees would have to use the plans

[16] Brigitte Madrian and Dennis Shea. *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior.* National Bureau of Economic Research Working Paper No. 7682, May 2000, p. 51.

organized by the firm as their primary insurance under the rules specified by the employer if they wished to claim the federal tax credit. Thus, to maintain stability in the insurance pool, employees of such firms would not have the right to opt out of the employer's plan. These employers would still be required to arrange for a payroll deduction and adjust withholdings, as most already do.

Many smaller employers today wish to contribute to their employees' health care, yet they face organizational burdens and high administrative costs in providing insurance themselves or they cannot provide affordable coverage.[17] Those that do contribute by sponsoring plans often do so only because of the design of the tax code. The tax features of the proposal would give many of these firms the attractive option of making a defined contribution to an employee-chosen plan not sponsored by the employer. To be sure, some firms now sponsoring insurance would decide—in most cases with the support of their employees—to end plan sponsorship and switch to a defined contribution. But that form of "crowding out" would be more efficient and beneficial to employees, since it would entail more choices. Less desirable instances of crowding out that might destabilize a company's risk pool would be reduced in two ways. First, the proposal requires employees to enroll in a company-sponsored plan if it is provided to all employees. Second, employees have the right to use their credit to offset the out-of-pocket costs of coverage for themselves or their dependents, which would make employer-sponsored coverage more affordable for many lower-income workers who decline it today.

A New Opportunity for Large Corporate Plans

This tax proposal would remove the current tax barrier to large corporations marketing their health plans widely to non-employees. It is common for large firms to take products initially developed as an internal service to the firm and market them to external customers, thereby deriving revenues from what had previously been an overhead cost for the firm. For example, General Motors formed the General Motors Acceptance Corporation (GMAC) out of its huge automobile loan service developed to help sell its cars. GMAC has now branched out into a broad range of financial services, including home mortgages, because the tax system does not deny the mortgage interest deduction to someone obtaining a mortgage from a car company. But only a few large companies have explored marketing their health plans to non-employees,most notably John Deere.[18] The employees of firms contracting with the Deere plan are still in an employer-sponsored plan,so they qualify for the tax exclusion. But the tax code does not give tax relief to individuals or non-employment groups signing up for the plan, and this has discouraged Deere and other companies from offering such coverage. The proposed tax credit would remove this obstacle, opening up a potentially large new market for existing corporate plans and an opportunity for many working families to obtain coverage under these plans.

Incentive for Employer Contributions

Under this proposal, the employer would continue to be the link to health coverage, and the employee would be obligated to enroll in a plan, so the proposal would not mean a reduction in employer involvement. Moreover, with this new tax credit for non-employer-sponsored coverage, there would be an incentive for many firms that do not do so today to make a financial contribution to insurance, since they could do so without the burden of sponsoring insurance, while still enabling their employees to enjoy the same tax benefits that would apply to sponsored insurance. Thus, while the tax conse-

[17] In a recent survey, for instance, 27 percent of small employers (with fewer than 50 employees) offering dependent coverage reported that their employees declined it because of the cost (*EBRI Issue Brief,* no. 226, October 2000).

[18] As part of its strategy to improve and coordinate care for its own workforce, Deere created its own HMO. To make the most efficient use of its new health facilities, the company then contracted with other firms to enroll their employees in the Deere plan. The Deere plan is now offered to federal employees in some areas under the FEHBP, as well, and to some Medicare and Medicaid beneficiaries. In fact, out of more than 400,000 individuals enrolled in the Deere plan, less than 20 percent are John Deere employees. See Stuart Butler. *Transcending Employment-Based Health Insurance.* Council on the Economic Impact of Health System Change, 1999, conference paper available at http://sihp.brandeis.edu/council/pubs/Butlertx.pdf.

quences of an individual obtaining insurance through an employer or any other source would cause some employers to close down their health plan and convert the benefit to cash income, those same consequences could induce these and many other employers to make a contribution to an "outside" health plan selected by the employee.

Self-Employment and Transitions

The credit would be adaptable for working-age individuals who are self-employed and for individuals either temporarily not working or leaving other health programs. For example, self-employed individuals would furnish the IRS with evidence of insurance and make appropriate adjustments to their estimated tax payments. If a worker chose to remain in his or her former employer's sponsored plan under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the credit would apply to the cost of coverage,as it would to any normal medical cost. If such a worker were self-employed, or worked for a firm that did not offer insurance, he would recover the credit for COBRA coverage through quarterly tax payments or withholding.

An unemployed person with an assigned credit similarly would face a reduced premium. If the person did not qualify for or choose the assignment option,he or she could obtain the value of the credit as an adjustment to his or her unemployment compensation. The tax credit for unemployed workers could be paid through the unemployment insurance system. This would require a funds transfer between the Treasury and the Department of Labor, with the money then distributed to state unemployment offices (similar to the supplemental benefit programs delivered in this way since 1958). The state unemployment offices also could take on responsibility for remitting premium payments to insurers. Early retirees would also be eligible for the credit, while the value of their health benefits paid by their previous employer would be taxable, unless converted into a cash contribution and shielded from taxation in some other way.

Administering the Program: Working with States to Make Insurance More Available

Reforming the federal tax subsidy system to channel more assistance to those who need help to afford coverage and care is only half the equation. The other half is ensuring that attractive and affordable health plans are available to individuals and families. In theory a credit can work in an insurance system that charges for its services according to a market assessment of a person's medical services and insurance risk. But this would require huge and carefully designed subsidies to certain individuals, and would be impractical.

A more practical approach has two elements. The first is to develop a subsidy system,like the one above, designed to deal with the great majority of individuals based on their income and medical needs. The second is for the federal government to work with states to make sure that new and affordable plans are available to families within a stable insurance market, and that plans are affordable for people who remain high-cost "outliers" despite the subsidy system.

This proposal seeks to do this through a federal-state partnership aimed at making available new kinds of group health plans at reasonable prices. To achieve this, the federal government would have to do three things. First, it would amend laws to create opportunities for new kinds of group plans. Second, it would make available grants to states under certain conditions to enable the states to reduce uninsurance by supplementing the federal refundable tax credit. And,third,the federal government would negotiate with states, during which a state could accept "default" federal insurance regulation and federally sponsored insurance groups, or it could implement, with federal approval, an alternative insurance arrangement designed to achieve the federal goals of reasonably priced health plans at reasonable prices and a reduction in uninsurance.

Potential New Insurance Groups

IMPORTANCE OF GROUP COVERAGE

One of employment-based coverage's central claims is that it is an effective way of forming relatively sta-

ble groups for insurance purposes. This is true to some extent, especially for larger firms, in part because the heavy tax bias today in favor of employer-sponsored insurance makes a firm's workforce in effect a "captive" group. But the benefits of employer-formed groups have been exaggerated, particularly for small employers, and they come at considerable cost in terms of reduced choice, "job lock," and other side effects.[19] Indeed, the problems of small employer-based groups have forced many states and insurers to create new groupings to achieve greater insurance stability, spread risk, and provide affordable premiums regardless of health status.

This proposal thus does not envision individual insurance as the principal alternative to today's employment-based coverage. For one thing, forming people into groups for insurance purposes achieves administrative economies and is a means of spreading risk. But, in addition, an intermediary institution can negotiate with insurers or providers in the interests of group members. This intermediary function is necessary to achieve efficiency and satisfaction in a market where the consumer is not typically a sophisticated buyer. Still, to achieve satisfaction and efficiency for the consumer, the goals of the intermediary must coincide with those of the consumer. For such reasons this proposal envisions the encouragement of other kinds of groups, particularly for individuals who do not have access to employer-sponsored insurance or for whom a group centered on the place of employment is not ideal.

Four types of groups are particularly attractive alternatives to traditional employment-based coverage:

Affinity Groups. Several common institutions in American communities are well placed to serve this function for insurance. For example, unions as "friendly societies" have had a long history of involvement in health care in the United States and elsewhere. Many unions are active in the organization of multi-employer health plans under the Taft-Hartley Act. Union plans also flourish in the FEHBP, in some cases offering associate membership to non-union members.

Many religious denominations also have a long history of providing insurance services for their congregations.[20] For lower-income African Americans and others, the church is a far more stable institution in the community than local, small employers, and one that has the long-term social welfare of families firmly in mind. In addition, the Catholic Church and other denominations sponsor networks of hospitals. Since churches, like unions and many other groups, routinely communicate with their members by mail, these intermediaries also present a lower-cost "piggyback" means of marketing health plans and reducing administrative costs.

This proposal does not envision these alternative groups acting as insurers themselves, but instead as buying agents that reach agreements with insurance plans that actually shoulder the risk. These organizations would form the group of purchasers and receive a fee from the insurer for performing marketing and management functions. This is the arrangement used by such organizations operating in the FEHBP.

Other affinity groups, such as farm bureaus and professional associations, exist in part to negotiate insurance packages for their members, but such groups face significant limitations that restrict the role they can play. A major impediment is the tax law, which denies tax benefits to most people who obtain coverage through groups not closely associated with their employment. (Where that impediment does not apply, such as to union plans in the FEHBP, alternative groups play a major role.) In addition, state-level benefit mandates and insurance regulations discourage many affinity groups from offering health insurance.

Associations. Various employment-related associations have arisen to group people together to obtain insurance without the employer directly

[19] Uwe Reinhardt. "Employer-Based Health Insurance: A Balance Sheet." *Health Affairs 18* (6): 124–32.

[20] Fraternal organizations, many of them church-affiliated, were a major source of health insurance (and even capitated health plans) earlier in the 20th century, but were forced out of existence largely by tax-subsidized employer plans and, later, by Medicaid; see David Beito. *From Mutual Aid to Welfare State.* Chapel Hill, NC: University of North Carolina, 2000, chs. 9, 10.

sponsoring coverage. These include health purchasing cooperatives and coalitions (HPCs) and multiple-employer welfare arrangements (MEWAs), and they also face restrictions at the state level that affect their insurance arrangement and benefits.

There have been proposals in recent years at the federal level intended to create new kinds of associations that would be free from many state restrictions, particularly state benefit mandates. The most important of these are HealthMarts and association health plans. While these proposals do raise concerns about their potentially disruptive impact on existing state efforts to devise affordable insurance groups because of possible risk selection,they could be vehicles for lower-cost group coverage.[21]

Federal Employees Health Benefits Program (FEHBP). While technically an employment-based system, the FEHBP actually serves the equivalent of a small country (with nearly 10 million covered individuals) and offers a broad choice of plans. While a federal worker's immediate employer does not sponsor plans, the place of employment is still the "entry point" for selecting plans, much like the process envisioned in this proposal. FEHBP plans are regulated at the federal level, through a combination of general statutory and administrative regulation supplemented by a process of negotiation between the Office of Personnel Management, on behalf of the federal government,and plans wishing to market through the FEHBP. Premiums are community rated, but costs and benefits vary widely.[22]

The FEHBP operates parallel to the systems for workers outside the federal government. There have been several proposals to open up the FEHBP to non-federal workers under various conditions, typically using a separate insurance pool.[23]

Large-Employer Plans. As noted earlier, the current tax laws discriminate against large corporations offering their health plan coverage to non-employees. Another major limitation on this opportunity is that the Employee Retirement Income Security Act (ERISA) does not protect such plans from state regulation unless they are made available to the employees of other ERISA-protected firms, or through federal programs such as the FEHBP.

A Federal "Default" System of Insurance Regulation

This proposal recognizes that stimulating the creation of new forms of group coverage not sponsored by employers involves two challenges. The first is to create an environment in which such alternatives are fostered, principally by removing any barriers to such plans. The second is to tackle the concern that such groups would be disrupted by the pressures of adverse selection.

Under the proposal the federal government would enact legislation to help make new forms of group insurance more widely available and affordable in each state. Each state would have the choice of allowing this federal structure to supplement or replace its own system of regulation, or proposing its own package of changes to achieve the same objectives as the federal structure, perhaps incorporating some of the federal steps. The federal government then would negotiate with the state on the final regulatory arrangement, withholding the proposed grant and applying some or all of the federal set of changes if there was not complete agreement.

The federal legislation would address four areas:

1. Premium regulation. ERISA and the Health Insurance Portability and Accountability Act (HIPAA) would be amended to include limitations on underwriting and to establish a minimum set of benefits. Currently HIPAA establishes certain minimum protections for enrollees in federal- and state-regulated plans, including those under ERISA. It establishes a minimum,which states can exceed,and it allows states to propose alternatives for certain provisions that can be accepted as sufficient by the federal government.

[21] For a discussion of the issues associated with such proposed new associations, see Elliot Wicks and Jack Meyer. *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?* Washington: National Coalition on Health Care, 1999.

[22] For a description of the FEHBP, see Harry Cain. "Moving Medicare to the FEHBP, or How to Make an Elephant Fly." *Health Affairs 18* (4): 25–39; Stuart Butler and Robert Moffit. "The FEHBP as a Model for a New Medicare Program." *Health Affairs 14* (4); Craig Caplan and Lisa Foley. *Structuring Health Care Benefits: A Comparison of Medicare and the FEHBP.* Washington, DC, AARP Public Policy Institute, May 2000.

[23] For instance, Senator Bill Bradley made such a proposal in his presidential campaign.

Federal law would be amended to encourage new types of group coverage. In particular, large affinity groups and associations would be permitted and protected from state regulation.

The proposed federal legislation would amend ERISA and HIPAA to require a minimum set of benefits in all plans for which the new federal tax credit could be used. Unless states negotiated alternative arrangements, they could not prevent plans containing these minimum benefits from being marketed, provided the plans met other applicable state and federal requirements. In addition, ERISA and HIPAA would be amended to require that all plans, including plans in the individual market, limit underwriting so that premiums for any particular plan option could vary at most only by age, sex, geography, and family type, and not by such factors as health status. As noted, this would go into effect unless a state negotiated an alternative arrangement with the federal government. Plans could place more limits on premium variation either voluntarily or under state regulation. The narrower premium variations typical in ERISA plans—chiefly by family type—would meet that requirement.

2. New types of group plans. Federal law would be amended to encourage new types of group coverage. In particular, large affinity groups and associations would be permitted and protected from state regulation. Federal law governing the FEHBP would be amended to permit a separate insurance pool for non-federal employees. Plans currently available in the FEHBP would be allowed to market to the new pool, if they wished, and other plans could market exclusively to the new pool, provided they met the general requirements of the FEHBP. While the current FEHBP is community rated, the premiums of plans offered to non-federal workers in particular would have to comply with the federal underwriting requirements specified above or a rating system agreed to between state and federal government. In addition, the plans offered to non-employees by ERISA-regulated companies would be regulated under ERISA rather than under state law.

3. A new grant program for states. Congress would enact a new grant program, discussed earlier, for states to supplement the federal tax credit to achieve near-universal affordable health care coverage. The grant program would contain two sets of funds:One would be based on the estimated value of the federal tax benefits unclaimed by those who did not purchase minimum insurance, and the other would be a $6 billion grant each year available to states on the basis of a federally approved state plan to reduce uninsurance according to agreed-on goals by making choices of affordable plans available in the state.

4. A federal-state compact. At least some of the federal reforms would go into effect unless a state proposed an agreeable alternative arrangement likely to achieve the same ultimate goal of affordable coverage for families eligible for the federal tax credit. A state might propose alternative premium rating requirements for non-ERISA plans and benefit requirements that made lower-cost plans widely available in the state. It could create a high-risk pool, and so reduce the need for underwriting restrictions. Furthermore, it could propose the use of state programs, including direct services through clinics and other facilities, to accomplish the equivalent of insurance coverage for some types of households. The state might also propose a modification of the federal law to permit the FEHBP and association plans to be made available in the state to integrate these new alternatives into its current insurance system.

New group plans and premium restrictions would raise concerns about adverse selection. For this reason the proposal also envisions the federal government working with states to experiment with new ways to limit this problem. This might take the form of high-risk pools and/or a reinsurance market. In reinsurance the health plans themselves buy insurance against ending up with an unusual portfolio of risk. In addition, states and the federal government could experiment with retrospective risk-adjustment pools in which plans pay amounts into the pool based

on their enrollment and receive money from the pool based on the actual paid claims of their enrollees.[24] An additional federally chartered national reinsurance pool or set of regional reinsurance pools could act as a final reinsurer between the cooperatives.

A share of the $6 billion federal grant would be available to states on reaching agreement with the federal government. The amount would be based on the costs of insurance and services still faced by lower-income households after they had received the federal credit. For these families,the grant could be used to reduce the cost of coverage, such as by subsidizing high-risk pools or by supplementing the federal credit. This proposal envisions states receiving a bonus if they achieve the objectives in the agreement, and losing some funds if they do not. This federal-state compact approach is similar to the approach taken in some provisions of HIPAA and the 1996 welfare reform legislation. In each case states could propose alternative means of achieving the federal objective, thereby avoiding certain provisions of the new federal law. In the welfare reform legislation, goals were set for reductions in welfare dependency, with bonuses available to those states that meet or exceed the agreed-on goal.

An additional obligation of a state, as a condition of receiving the federal grant, would be to identify a fallback private health plan and/or government program for any employed individuals (and their dependents) who did not select a specific plan at their place of work. Employers would enroll automatically in the plan those employees who did not choose an alternative plan containing the minimum required coverage.

Are Institutions Capable of Carrying Out their New Administrative Functions?

The federal and state governments, as well as the private sector, would have a number of administrative obligations under the new program.

The Federal Government

Administration of the proposed program would be shared by federal and state governments, but with key roles for employers and insurers. The Treasury, through the Internal Revenue Service, would administer the federal tax credit. For the vast majority of individuals, the vehicle for distribution of the credit would be the normal withholding process by the employer, with the amounts reconciled in tax returns. Some small modification of the worksheets for withholding and tax returns would be needed. The Treasury would need to monitor individuals assigning their fixed credit to a health plan,especially those who did not file income tax returns, but this would not place significant additional requirements on the Treasury.

There would need to be coordination between the Treasury and the Department of Labor to deliver the value of the credit to unemployed individuals through the state unemployment insurance system. If premium payments also were handled through unemployment offices, the Labor Department would have to remit credit and premium payments to an individual's chosen plan. This would be a new obligation for the department, handled through local employment offices. In addition, the Labor Department would be the principal federal agency monitoring employer compliance with the requirements for establishing payroll reduction plans and remitting premiums.

The Health Care Financing Administration (HCFA) would be a logical choice to broker agreements with the states and to monitor these agreements, and to be responsible for changes in federal insurance rules. But it would be impossible for the agency to undertake these responsibilities with its current resources and bureaucratic culture—HCFA has been unable to carry out several responsibilities assigned by Congress properly because of a lack of resources. The experience of implementing and enforcing HIPAA indicates shortcomings at HCFA in data collection, oversight, and guidance of states. HCFA also has been unable to handle its obligations under Medicare. The new requirements in this proposal represent yet another reason to overhaul the agency. The Labor and

[24] For a review of the issues involved in blended approaches to risk adjustment, see Linda J. Blumberg and Len M. Nichols. "Health Insurance Market Reforms: What They Can and Cannot Do." Urban Institute, 1998. See also Joseph Newhouse. "Risk Adjustment: Where Are We Now?" *Inquiry* (Summer 1998).

Treasury departments, responsible for some provisions of HIPAA,also have some weaknesses, though much less serious ones.[25]

A possible solution to HCFA's inability to carry out many of the proposed new functions would be to combine these functions with structural reforms already proposed for Medicare. Such Medicare proposals include creation of a "Medicare Board," separate from HCFA, to manage a system of competing health plans. The board would be modeled on the Office of Personnel Management's role in the FEHBP, leaving HCFA to focus on the traditional fee-for-service Medicare program. Establishing the board is seen as a way of creating an agency with a very different staff and culture from HCFA—one that would create and manage competitive markets. Given that the federal functions under the proposed tax credit system would be similar to those of a Medicare board—establishing conditions for affordable plans to exist in a competitive market—it might be possible to include them in a widened role for such a board.

States

New responsibilities for states would accompany the additional funding available through the new federal grant to states. After negotiating a plan and goals to reduce uninsurance, a state would have to develop a mechanism to supplement the federal tax credit for eligible workers and to deal with those who did not purchase minimum insurance and had a plan or program selected for them. States with an income tax might choose to use the employment-based state tax withholding system to deliver such a supplement. Otherwise they would have to devise an alternative automatic system, such as payments to insurance companies, or enable households to claim assistance directly from the state. In cooperation with the federal government, states also would be responsible for administering the credit and premium payment functions for the unemployed. Supplemental benefit programs and temporary programs to provide supplemental cash benefits have been delivered in this way since the 1960s. A similar process could be created with the unemployment insurance system to pay health insurance premiums for unemployed Americans; with additional administrative funding to defray the costs,the same system could be used to provide continued health insurance coverage.

To meet their agreed-on goal of reducing uninsurance,states would have to use the additional federal funds to expand existing programs—or develop new ones—to achieve targeted levels of coverage. In addition, they would have to work with insurance companies to devise ways of introducing modified community rating along with a reinsurance and/or risk-adjustment system. This proposal envisions the states having the flexibility to accomplish these goals. In addition,each state would have to specify a default enrollment system for those employees of firms in the state who did not indicate a preferred plan to their employer (and were not covered under a spouse's plan or a government program).

Employers

New obligations on employers would not be onerous. Employers would be required to inform their employees about the tax credit program and to make available the necessary federally produced enrollment forms. Employers already have to arrange tax withholding, so they merely would have to adjust that amount according to a worksheet to include the credit in their withholding calculations. Employers also would be required to provide the IRS with proof of insurance for each worker, which could easily be done by sending on an insurance statement received from the insurer. Further, employers would have to set up accounts for payroll deductions to be placed for employees and make payments from these accounts to health plans. For large employers this would be similar to creating flexible accounts. For small employers it would be a new obligation, but a small one that could be carried out routinely by a payroll firm.[26]

[25] Karen Pollitz, Nicole Tapay, Elizabeth Hadley, and Jalena Specht. "Early Experience with 'New Federalism' in Health Insurance Regulation." *Health Affairs 19* (4) (July/August 2000).

[26] See Butler, October 1999.

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confused with proposals to establish a federal requirement for comprehensive coverage and specific benefits. The basic plan is intended to provide *minimum*, primarily catastrophic insurance protection,not comprehensive coverage. The vast majority of households would choose more extensive coverage, but requiring typical coverage as the required minimum would make insurance prohibitive to lower-income families, as the experience of state mandates has demonstrated.[27] In addition, the minimum would be in the form of broad areas of coverage, such as hospitalization and major medical, similar to the requirements for plans in the FEHBP or the California Public Employees' Retirement System (CalPERS), rather than a precisely defined set of specific benefits, such as Medicare fee-for-service. CalPERS operates much like the FEHBP, but for California state employees. For a minimum plan to meet the conditions for the credit, it would have to match the federal base plan's broad features, and its benefits would have to be at least equivalent to the federal benchmark in actuarial terms.

The Process of Reform

The New Program and American Values

The proposed new system of insurance has a radically different dynamic from today's arrangement, yet its link with the place of employment fits in with the familiar aspects of today's system that most Americans are loathe to abandon. Since enrollment and the financial transactions associated with insurance would continue to be at the place of work, it would look very much like today's system.

In several respects, however, the new system would be much more in line with the general American view of economic relationships and health care than is today's employment-based system. For one thing, most workers would have far more choices than they have now. In addition, they would own their own policy as individuals or members of a group. This would give families far greater consumer control over their insurer, and insurers generally would have the same incentive to satisfy enrollees (rather than their employer) as plans do in FEHBP.

Workers who are not in employer-sponsored plans also could obtain their insurance through intermediaries they trust to protect their interests, rather than having to deal directly with insurers in the individual market. Americans have indicated, through their support for patients' rights legislation and in responses to surveys, that they want the government or another intermediary to exert some control over health insurers. They also have indicated that churches, unions, and other such organizations are often more attractive intermediaries than employers.[28] The proposed system would remove many of the obstacles that make it difficult for families to obtain coverage through these groups.

By delinking tax benefits and employer sponsorship of insurance, the proposed system would achieve the true portability Americans want. Workers typically would be able to remain with their chosen health plan, even when they change jobs, merely by informing their new employer of their existing plan when they sign on for the required payroll deduction and tax withholding.

Getting from Here to There

Americans are nervous about radical change in their health care, including sudden changes in the tax treatment of their benefits, even if in all probability the change would be to their advantage. To address this,the proposal could be introduced in stages, over a long period, to make the transition as gradual and

[27] Melinda Schriver and Grace-Marie Arnett. "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations." *Backgrounder* 1211, Washington: The Heritage Foundation, August 14, 1998.

[28] A recent poll conducted for the Democratic Leadership Council, for instance, found 72 percent support for a proposal to give employees the option of receiving a tax break if they chose to "purchase their health care through an outside organization such as the AARP, union, a church, or a community-based purchasing co-op instead of through their employer." If given that option, half the respondents said they would choose it; see Mark J. Penn. "Health Care Is Back." *The New Democrat Blueprint* (Spring 2000): 70, 71. Other surveys indicate similar support for non-employment groups as vehicles for insurance, and a recent poll of women conducted for the Center for Policy Alternatives indicated that 72 percent of women would like their health insurance to be independent of their employment (*Women's Voices 2000,* Center for Policy Alternatives and Lifetime Television, Washington, DC, 2000). See also "Focus on Women." *The New York Times* (September 27, 2000).

Because the proposed system would operate through the place of employment, it would have the major political advantage of not appearing to be a major departure from the existing familiar arrangement.

politically feasible as possible. New refundable credits for households without access to employer-sponsored coverage already have been proposed in Congress and would be the logical first step. The second step would be to introduce the new state subsidy program, probably as an amendment to S-CHIP, to enable states to supplement the credits with federal-state funds. The second step also would require employers to administer the payroll deduction system. The third step would be for the federal government to modify HIPAA and ERISA, and to work with the state governments to introduce rating restrictions, basic benefits, and a risk-adjustment system. With plans available based on these regulatory changes, it would be more feasible to implement the core tax reform, which would replace the tax exclusion with a comprehensive tax credit system.

Political Feasibility

The purpose of this proposal is to achieve universal coverage in a way that relies on markets and choice rather than new government programs. To do so would change the way most health care for working households is subsidized through a major reform of the tax treatment of health care. But while the vision of change is comprehensive, one must acknowledge that Americans are reluctant to embrace radical change that disrupts familiar arrangements. Therefore, the actual introduction would have to take place in stages, each one explained clearly and extensively to build public support.

Because the proposed system would operate through the place of employment, however, it would have the major political advantage of not appearing to be a major departure from the existing familiar arrangement. But the tax credit approach has other political advantages. For example, the basic idea already has broad bipartisan support. Major tax credit bills have been introduced regularly in Congress since 1993, and several were introduced in the 106th Congress or put forward as proposals by groups of members of widely differing political persuasions. Both presidential candidates in 2000 also embraced tax credits as a part of the solution to uninsurance.

While the proposal would place new requirements on states, it also would help to relieve the burden on states caused by uninsurance and uncompensated care. The federal credit itself would reduce the incidence of uninsurance, and states could combine it with their own subsidies to enable families to afford coverage, thanks to the new federal grant to states. Of course, many states might not like federal preemption of insurance regulation and the obligation to meet targets for reductions in uninsurance, but they would have the flexibility to modify their own regulations to achieve the targets, and the new federal grant would be a clear inducement. The recent welfare reform experience indicates that the combination of agreed-on targets, flexibility, and financial awards to states can be a political winner, and a similar approach is incorporated into this proposal.

There no doubt would be a range of reactions among insurers and health care providers, but the tax credit approach has already won strong support among such key groups as the American Medical Association and the National Association of Health Underwriters. This approach also has been gaining ground among associations representing managed care plans and insurers.

Larger employers and unions traditionally have opposed changes in the tax code that would finance alternatives to the traditional employer-based system, fearing they would cause employer-sponsored insurance to unravel. But industry support is growing, in part because recent tax credit proposals have included protections for employer-sponsored coverage, and in part because of an increasing recogni-

tion of the limitations of employer-sponsored coverage, especially for employees of small firms. The U.S. Chamber of Commerce, for instance, now supports an income-related tax credit, as well as expanding ERISA to facilitate insurance pools based on associations and community-based organizations. The additional paperwork requirements in the proposed system would be only a minor change for most mid-size and larger employers, but would be seen as burdensome by many small firms. The requirement to assess the cash value of employer-sponsored benefits would be more problematic for employers, both because of the burden of making the calculation and because of concern about employee reaction to varying total compensation for employees with the same total income.

So far, the major unions have continued to oppose tax-based initiatives, even though many of them actually operate plans that could prosper under a tax credit system. But emphasizing the protections for large employment-based plans negotiated by unions, and the opportunities for new union-sponsored plans in the service and small-business sector, could reduce this opposition.

Conditioning tax relief on obtaining a minimum plan would make no practical difference to most families, since they either have or want good coverage. What would cause more consternation is taxing employer-paid benefits, even with a new tax credit. The idea of restricting or eliminating the tax exclusion to raise government revenues has been proposed several times and has encountered strong opposition. But this proposal contains clear advantages to employees contemplating new taxes on a previously tax-free fringe benefit. They would qualify for a credit that in most cases was approximately the same as their current exclusion or larger, thanks to the sliding-scale nature of the credit and the additional tax expenditure. Moreover, the tax change would allow families new tax relief for out-of-pocket costs, so there would be a visible benefit every time a person visited the doctor or paid for a prescription. And even though upper-income workers generally would face a net tax increase, in many cases this would be because of a conscious decision to take more of their compensation in cash income rather than fringe benefits. Thus the tax change would be an attractive swap for most workers.

Other Issues

Cost and Efficiency

This proposal likely would increase pressures to use medical services efficiently and to control costs. For one thing, eliminating the exclusion and making employer subsidies explicit would spur employees to consider value for money much more carefully and to exchange unnecessary benefits for cash. The exclusion has long been recognized as encouraging wasteful overinsurance by middle- and upper-income families. For another, giving workers the opportunity to join large groups outside the place of work would sharpen plan competition and allow workers in small firms, usually with costly and inefficient coverage, to join more efficient plans. Making it more possible for families to join plans that reflect their preferences also would improve economic efficiency.

Efficiency also would be improved by reducing the administrative costs currently associated with plans covering individuals or group plans serving the employees of small firms (including the high costs borne by small employers in arranging insurance). The proposal envisions many workers now in very small employer groups switching to much larger non-employment groups. Small employers currently providing insurance also would face lower costs in their new role. The potential reduction in administrative costs is difficult to estimate; it would depend on the types of plan that emerge. In estimating versions of the Heritage Foundation proposal, the Lewin Group assumed administrative costs of 19 percent of benefit costs, based on plans covering large numbers of people in the individual market.[29] The FEHBP market suggests that costs could be much lower. Others have estimated that, with automatic workplace enrollment and payments, the administrative costs of a tax credit system could be a low as 7.5 percent.[30]

[29] Sheils et al., 1999, p. 45.

[30] Etheredge, 1999, p. 6.

In any event, if large groups formed in the market, with enrollees coming from today's individual and small-group market, the average administrative costs of insurance would tend to fall.

Subsidies to low-income families for affordable insurance would encourage more Americans to leave welfare and unemployment permanently by removing a major obstacle to long-term private employment in the small-business sector. The system would have some marginal effects on work effort because of the credit design. But,although the sliding-scale credit does include a traditional phase-out mechanism, the cost/income ratio determining the marginal credit percentage leads to only a gradual reduction in the value of the credit for a given amount of health spending as income rises. The equivalent effective marginal tax rate for the credit phase-out drops at particular incomes, or bend points,as income rises. The rate also declines for any income level as expenses rise. For a family of four with $7,000 worth of expenses, for instance, the rate is 4.1 percent for incomes up to $45,000, declining to 0.8 percent for incomes of $100,000.

Achieving Greater Equity

Tax-based approaches of this kind sometimes are seen as less efficient because part of the tax expenditure goes to households that are insured already. Currently some three million workers and dependents purchase some level of health insurance, even though they are unable to claim tax relief. Moreover, if tax credits were available to offset out-of-pocket costs associated with employer-provided plans, many other insured families would be able to claim additional tax relief. Hence the cost per newly insured individual typically would be higher than approaches that restrict services or program eligibility only to those who are uninsured.

A key objective of tax-based approaches to uninsurance, however, is to reduce the large inequities in the current tax treatment of health care costs. If a policy aim is to provide similar levels of assistance to families with the same income and health needs, similar subsidies must be provided to families currently with or without insurance. To do otherwise would discriminate against families that had taken steps to protect not only themselves but also their community by reducing the likelihood that they would incur medical expenses they could not pay. Moreover, the argument that a tax credit approach would mean subsidizing people who are already insured is not unique to this approach. Any program designed to assist individuals without insurance is bound to crowd out some existing insurance if the program is more generous. That is why Medicaid expansions and other efforts by states to cover uninsured families lead to at least some erosion of employer-sponsored insurance. If the equitable allocation of subsidies is an objective, this effect cannot be avoided.

Quality of Care

While the quality of care available to families under the proposal would depend on many factors, it is possible to make some observations about probable effects. One is that the wider coverage resulting from the reform would mean that many more Americans would receive their care through plans that monitor their health, rather than through emergency rooms and occasional visits to the doctor. Second,most families would have greater choice of plans than they do now, and thus could select plans that better meet their medical needs. Third, a more consumer-driven market would lead to more usable information that enables families to pick more appropriate plans, because plans would be under greater pressure to satisfy enrollees (rather than their employers). Increased choice and competition in a market makes it more economical for third parties, such as consumer organizations, to obtain and distribute information to prospective enrollees—a phenomenon seen in the FEHBP. ■

Butler Proposal

Key Elements

Stuart M. Butler has outlined a new proposal to achieve near universal coverage for health insurance that is built on the following key elements:

A REFUNDABLE TAX CREDIT available to working households would replace the current tax exclusion accorded to employees. Employees could no longer exclude from their taxable income the amount employers contribute on their behalf to health insurance premiums.

WORKERS WHOSE EMPLOYERS sponsor coverage would have to use the credit to get coverage at work. Other employees and individuals could use their tax credit to buy coverage from a range of additional sources. These would include plans offered by employers, association plans, and plans offered by affinity groups such as churches, unions, and so on.

ALL EMPLOYERS, regardless of whether they sponsored coverage, would have to undertake a "clearinghouse" function, which could include adjusting employee tax withholdings to reflect their credit, creating an automatic enrollment mechanism for insurance, and setting up a payroll deduction and payment system for employees to pay their chosen plan.

TO RECEIVE A NEW FEDERAL GRANT to supplement the tax credits, states would have to develop a plan acceptable to the federal government to make coverage more affordable for low-income workers.

About the Author

STUART M. BUTLER, PH.D., is Vice President, Domestic and Economic Policy Studies, at The Heritage Foundation. Born and educated in Great Britain, where he earned a Ph.D. in American economic history from St. Andrews University in Scotland, Butler is considered one of Washington's most innovative thinkers. He was named one of Washington's "dozen key players" on health care reform by the *National Journal*, and played a key role in the intellectual and policy revolution that produced the 1996 welfare reform legislation. His books include, *Enterprise Zones: Greenlining the Inner Cities; Privatizing Federal Spending; Out of the Poverty Trap* (with Anna Kondratas); and *A National Health System for America* (with Edmund Haislmaier), which in 1989 presented a blueprint for reform based on consumer choice and competition.