Severing the Link Between Health Insurance and Employment

AN EBRI-ERF POLICY FORUM

EDITED BY DALLAS L. SALISBURY

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Established in 1978, the Employee Benefit Research Institute (EBRI™) is the only nonprofit, nonpartisan organization in the United States totally committed to original public policy research and education on economic security and employee benefits.

EBRI's overall mission is to encourage, to contribute to, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

EBRI does not lobby or endorse specific approaches. Rather, it provides balanced and unbiased analysis of alternatives based on the facts. Through its activities, EBRI advances knowledge and understanding among the public, the news media, and government policymakers of how employee benefits function and why they are critically important to our nation's economy.

Since its inception two decades ago, EBRI has grown to include a cross section of the public and private sectors with an interest in economic security programs. EBRI is funded by membership dues, grants, and contributions from foundations; businesses; labor unions; trade associations; health care providers and insurers; government organizations; and service firms, including actuarial firms, employee benefit consulting firms, law firms, accounting firms, and investment management firms. International members look to EBRI's work to gain understanding of the U.S. economic and employee benefit systems.

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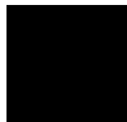

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About EBRI-ERF Policy Forums

The Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) holds two policy forums per year. The goal of the policy forums is to bring together a cross section of EBRI sponsors, congressional and executive branch staff, benefit experts, and representatives from academia, interest groups, and labor to examine public policy issues. It is a roundtable discussion featuring verbal and written exchange among speakers and participants. The roundtable format is designed to encourage discussion.

Past EBRI-ERF policy forums include:

12/2/98 "Beyond Ideology: Are Individual Social Security Accounts Feasible?"

5/6/98 "The Future of Medical Benefits"

12/03/97 "Do Employers/Employees Still Need Employee Benefits?"

04/30/97 "Retirement Prospects in a Defined Contribution World"

12/04/96 "Assessing Social Security Reform Alternatives"

04/30/96 "Comprehensive Tax Reform: Implications for Economic Security and Employee Benefits"

12/07/95 "The Changing World of Work and Employee Benefits"

05/11/95 "When Workers Call the Shots: Can They Achieve Retirement Security?"

10/26/94 "The Future of Employment-Based Health Benefits"

05/04/94 "Retirement in the 21st Century: Ready or Not?"

10/06/93 "The Changing Health Care Delivery System"

05/05/93 "Pension Funding and Taxation: Achieving Benefit Security"

12/01/92 "Rationing: Making Choices and Allocating Resources in the Health Care Delivery System—Implications for Access, Quality, and Costs"

04/29/92 "Paternalism vs. Empowerment: What Benefits Should/Will Employers Provide?"

09/25/91 "Retirement Security in a Post-FASB Environment"

05/02/91 "Pension Portability and Preservation: Assuring Adequate Retirement Income in the 21st Century"

10/04/90 "Winners & Losers in Reforming the U.S. Health Care System"

Preface

Health insurance in the United States has been tied primarily to employment since the widespread coverage expansion of the 1950s. Group benefits provided cost and administration advantages, due to the ability to "pool" together a large number of individuals and their health risks. The federal income tax has allowed employers to deduct the cost of health insurance as a business expense, and has allowed employees to receive it as a "tax-free" benefit. Since the mid-1980s, the ability of the individual to deduct the cost of personally purchased health insurance has been subject to substantial restrictions.

Proposals have been set forth for many years that would change the tax treatment of employment-based health insurance. The current round of proposals focus on tax credits and/or individual deductibility. The prior round (1994–1996) revolved around proposals for a flat-rate income tax or a consumption-based tax system, either of which would have changed the tax treatment of health insurance provided at work.

A central issue in the tax discussions of at least the past 20 years has been a desire to expand the number of Americans with health insurance. There has been an ongoing debate over whether tax change would increase or decrease coverage levels, but little quantitative analysis was undertaken to inform this debate.

With that need in mind, the Employee Benefit Research Institute–Education and Research Fund (EBRI-ERF), with funding from the Robert Wood Johnson Foundation, commissioned the analyses that were presented and discussed at the 46th policy forum held by the organization since 1979. The policy forum, held in Washington, DC, on May 5, 1999, was on the topic, "Severing the Link Between Health Insurance and Employment" The policy forum examined the link between health insurance and employment, how various federal policies may put that link at risk, and the implications of these policies for workers, employers, and the government. The goal of the policy forums was to bring together a cross section of EBRI sponsors, congressional and executive branch staff, benefit experts, and representatives from academia, interest groups, and labor to examine public policy issues.

This book integrates the papers from the policy forum into a single work. The introduction, written by Stephen Blakely of EBRI, sets the stage for the remaining sections of the publication. Blakely highlights segments of the discussion, and effectively provides an "executive summary" of the policy forum. The chapters that follow present the results of a public opinion survey undertaken specifically for the policy forum; quantitative analyses of the implications of tax change on health insurance coverage; commentaries on public policy and political concerns and motivations; commentaries on the range of possible unanticipated consequences of change; and varied assessments of what the future holds. Overall, the volume provides the most comprehensive review available today of the possible implications of changing the tax system as it applies to employment-based and individual health insurance.

I want to thank Paul Fronstin, Pamela Ostuw, and Alicia Willis for organizing and conducting the policy forum; Cindy O'Connor for production of forum materials and the book; Steve Blakely, Deborah Holmes, and Lynn Miller for copyediting; all of the forum authors and participants for their contributions; Mathew Greenwald & Associates for an excellent survey; and the Robert Wood Johnson Foundation for funding.

EBRI was founded in 1978 by leaders in the employee benefits field with a vision of building an objective research and education organization. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

This volume carries forward the mission of providing a basis for sound decision making and program design. It is dedicated to those in the nation who have worked for decades to provide the nation with health care, health insurance, health quality and health information.

Any views expressed are of the authors and should not be attributed to the officers, trustees, members, or staff of EBRI or its Education and Research Fund. In publishing this work, EBRI-ERF is making no effort to influence any specific legislation; rather, it is seeking to provide decision makers with information that might help them to evaluate proposals.

Dallas L. Salisbury
President & CEO
Employee Benefit Research Institute
Chairman & CEO
Consumer Health Education Council

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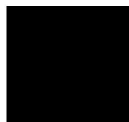

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Congressman Benjamin L. Cardin has represented Maryland's Third Congressional District in the House of Representatives since 1987. He is a member of the Ways and Means Committee, Ranking Member of the Human Resources Subcommittee, and a member of the Social Security Subcommittee. He also is a commissioner on the Commission on Security and Cooperation in Europe (the Helsinki Commission). In 1998, Cardin was appointed Chairman of the Special Study Commission on Maryland Public Ethics Law by the MD General Assembly. In 1997, he co-chaired the Bipartisan Ethics Task Force in an effort to reform ethics procedures in the House of Representatives. He also holds leadership positions on the Organization, Study and Review Committee and the Steering Committee of the Democratic Caucus and serves as Assistant Democratic Whip. As a Maryland legislator, Cardin served in the Maryland House of Delegates from 1967–1986. He was Speaker from 1979–1986 and prior to that served as chairman of the Ways and Means committee from 1974–1979. As Speaker, he was credited with reforming Maryland's property tax system, the school financing formula, and the ethical standards for elected officials. A 1967 graduate of the University of Maryland School of Law, he earned his B.A. degree in 1964 from the University of Pittsburgh. He also holds several honorary degrees and has received numerous awards.

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selection in Medicare HMOs and the effectiveness of alternative approaches for risk adjusting HMO payment rates, examining alternative methods for using competitive bidding for awarding Medicare risk contracts, and issues surrounding the expansion of Medicare to include provider-sponsored organizations. Before joining the PPRC, Cox was a Senior Economist at the Federal Trade Commission Bureau of Economics.

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Nancy W. Dickey, a board-certified family physician from College Station, TX, was elected President-Elect of the American Medical Association in June 1997, and assumed the role of President in June 1998. Prior to her election, Dickey served as Chair of the Board of Trustees from November 1995 to June 1997 and as its Vice Chair from 1994–1995. Elected to the AMA Board of Trustees in 1989, she served as Secretary-Treasurer of the AMA from 1993–1994 and as a member of the Board's Executive Committee since 1991. Dickey is the program director for the Brazos Valley Family Practice Program associated with the Texas A&M University in College Station, TX. She is a Fellow of the American Academy of Family Physicians, and has served as Vice President of the Texas Medical Association from 1986–1987 and as a Delegate to the Texas Medical Association from Fort Bend County Medical Association from 1984–1989. A graduate of the Stephen F. Austin State University, she received her medical training at the University of Texas Medical School at Houston, where she was a recipient of the Distinguished Alumni Award.

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istration of both traditional and managed care group health plans. He is often quoted on and writes on health care economics and managed care quality issues in the business and trade press. Jacobsen is also a member of a collaborative advisory panel on HEDIS, sponsored by the RAND Corporation, Harvard University, and the National Committee on Quality Assurance (NCQA). Jacobsen is a graduate of Merrimack College (Andover, MA) and has also attended the University of Michigan's Executive Program.

Mary Nell Lehnhard is currently Senior Vice President, Policy and Representation, at Blue Cross and Blue Shield Association (BCBSA). She is responsible for developing and implementing strategies (lobbying, grassroots, political) for representation of Association policies to Congress, the administration, and associations of state legislators/regulators. She is responsible for Association policy on federal legislative issues that affect Plans' health care business. Prior to joining BCBSA in 1980, Lehnhard was a professional staff member for the Subcommittee on Health, Committee on Ways and Means with the U.S. House of Representatives. She was also a legislative analyst for the Congressional Research Service of the Library of Congress. Lehnhard received her B.S. degree in chemistry and economics from the University of Arkansas.

Merrill Matthews, Jr., is the director of the Center for Health Policy Studies at the National Center for Policy Analysis (NCPA), a Dallas-based public policy research institute founded in 1983. The NCPA concentrates on health care, tax, and environmental issues. Its studies have also examined issues dealing with Social Security, education, crime, and privatization. Matthews travels to Washington, DC, regularly to brief congressional members on the NCPA's health care reform proposal, has testified many times before Congress on health care reform issues, and appears frequently on C-SPAN and CNBC. He also has an extensive background in medical ethics, and lectures and consults on medical ethical issues. He currently serves on the University of Texas Southwestern Medical School's Institutional Review Board for Human Experimentation and is the ethicist for the medical ethics committee at Richardson Medical Center. Matthews is an advisor to the American Legislative Exchange Council (ALEC) Health Care Task Force. He has written numerous articles and reviews and has a regular column in *Investor's Business Daily*. Matthews has a Ph.D. in philosophy and humanities from the University of Texas at Dallas, and has taught philosophy at the college level.

Len M. Nichols joined the Health Policy Center at the Urban Institute in November of 1994. He is currently working on a variety of projects under the general rubric of health reform: insurance market regulation, the elasticity of demand for health insurance of employers and of workers, the relative attractiveness of alternative risk pooling arrangements, the effect of tax policy on health insurance purchase decisions, health insurance purchasing cooperatives, and private insurance options for Medicare. Nichols is a member of the Competitive Pricing Advisory Commission (CPAC) for the U.S. Medicare program. He is also a consultant to the World Bank and to the Pan American Health Organization on the use of household surveys to analyze health service utilization by the elderly. Finally, Nichols is a member of technical advisory panels to the Health Resources and Services Administration, and Agency for Health Care Policy and Research. Immediately before coming to the Urban Institute, Nichols was the Senior Advisor for Health Policy at the Office of Management and Budget (OMB). He served in this capacity during 1993–94, when he managed and coordinated cost and revenue estimation for President Clinton's Health Security Act (HSA) and its congressional successors. He was part of the staff of the original Health Care Task Force. Nichols received his B.A. in economics and business from Hendrix College, a M.A. from the University of Arkansas, and his M.S. and Ph.D. in economics from the University of Illinois (Urbana-Champaign).

Thomas Rice is Professor and Chair of the Department of Health Services. He teaches courses in health economics, health care cost containment, research methodology, and current issues in health policy. Rice received his Ph.D. in Economics at the University of California at Berkeley. He has conducted research projects

and published in a number of areas, including: physicians' economic behavior; health insurance for the elderly; the Medicare program; health care cost containment; the role of competition in health care reform; and managed care. Rice has testified before the U.S. Congress numerous times on various health policy issues. In 1988, he received the Association for Health Services Research Young Investigator Award, given to the outstanding health services researcher in the United States age 35 or younger. In 1992, he received the Thompson Prize from the Association for University Programs in Health Administration, awarded annually to the outstanding health services researcher in the country age 40 or under. Rice is currently editor of the journal, *Medical Care Research and Review*. His new book, *The Economics of Health Reconsidered*, was published in April 1998.

Dallas L. Salisbury is President and CEO of the Employee Benefit Research Institute (EBRI), Washington, DC. He joined EBRI at its founding in 1978. He is also chairman and CEO of the American Savings Education Council (ASEC), a partnership of public- and private-sector institutions that undertakes initiatives to raise public awareness about what is needed to ensure long-term personal financial independence. Salisbury is currently a member of a National Commission on Retirement Policy and a separate National Study Panel on Social Security Reform, the Board of Directors of The Health Project, and the Advisory Board of the National Academy on Aging. He is a member of the General Accounting Office Social Security Advisory Panel, and an advisor to the Urban Institute on Social Security reform analysis. He serves on many editorial advisory boards, including those of *Employee Benefit News*, *Benefits Quarterly*, *Employee Benefits Journal*, and *Healthplan: The Magazine of Trends, Insights and Best Practices*. Salisbury is a Fellow of the National Academy of Human Resources, the recipient of the 1997 Award for Professional Excellence from the Society for Human Resources Management, and the 1998 Keystone Award of the American Compensation Association. He has served on the Secretary of Labor's ERISA Advisory Council, the Presidential PBGC Advisory Committee, is an advisor to numerous government agencies and private organizations, and is on committees of many professional organizations. He has written and lectured extensively on economic security topics. He was one of 39 statutory delegates to the 1998 National Summit on Retirement Savings hosted by President Clinton and congressional leaders, and moderated one of two general session panels. The EBRI/ASEC Choose to Save™ education campaign was featured in the other general session panel. Prior to joining EBRI, Salisbury held full-time positions with the Washington State Legislature, the U.S. Department of Justice, the Pension Benefit Guaranty Corporation (PBGC), and the Pension and Welfare Benefits Administration of the U.S. Department of Labor. He holds a B.A. degree in finance from the University of Washington and an M.A. in public policy and administration from the Maxwell School at Syracuse University.

Carl E. Scott is from Blackfoot, ID, and attended Idaho State University. He began his career with Mutual of Omaha as a salesman with the Squires Agency in Pocatello, ID. In 1969, he became a National Sales instructor at Mutual's Home Office in Omaha, NE. At the present time, he directs the Individual Marketing Division, which develops, implements, and manages individual life, health, and small group product lines/market segments for all distribution channels. He also directs the company's Direct Response Marketing and Communication Divisions. Scott has been actively involved in health care related issues through his work with the Health Insurance Association of America as well as Mutual of Omaha's Washington, DC, office.

Congressman John Shadegg was elected to represent Arizona's Fourth Congressional District in 1994. He has rapidly established a reputation in Congress as a leading advocate for reduced government spending, a balanced budget, and the reestablishment of state and individual rights. He is a newly appointed member of the Commerce Committee. From 1983–1990, Shadegg served as Special Assistant Attorney General. He is the Founding Director of the Goldwater Institute for Public Policy and is

the former President of the Crime Victim Foundation. He received his B.A. degree and J.D. from the University of Arizona.

Kenneth E. Thorpe is the Robert W. Woodruff Professor of Health Policy and Chair, Department of Health Policy and Management, Rollins School of Public Health, Emory University. Most recently, he was the Vanselow Professor of Health Policy and Director, Institute for Health Services Research at Tulane University. Thorpe received a Ph.D. from the RAND Graduate School, M.A. from Duke University, and B.A. from the University of Michigan. He was previously a professor of Health Policy and Administration at the University of North Carolina at Chapel Hill, Associate Professor and Director of the Program on Health Care Financing and Insurance at the Harvard University School of Public Health, and Assistant Professor of Public Policy and Public Health at Columbia University. Thorpe has also held visiting faculty positions at Pepperdine University and Duke University. Thorpe was Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services. In this capacity, he coordinated all financial estimates and program impacts of President Clinton's health care reform proposals for the White House. He also directed the administration's estimation efforts in dealing with congressional health care reform proposals during the 103rd and 104th sessions of Congress. As an academic, he has testified before several committees in the U.S. Senate and House on health care reform and insurance issues. Thorpe has received several awards for his work and has authored and co-authored numerous articles, book chapters, and books. He is a frequent national presenter on issues of health care financing, insurance, and health care reform at health care conferences, television, and the media. He is a fellow of the Employee Benefit Research Institute.

Christopher Topoleski, is a Senior Associate with the Health Economics Practice of Barents Group, LLC of KPMG LLP. He has been involved in analyzing private and public sector health policy with an emphasis on health care financing and delivery, alternative health insurance strategies, program evaluation, and publicly financed health care programs. He has analyzed the availability and comparison of benefits and premiums offered by Medicare risk HMOs in specific market areas and the features of supplemental benefits offered to Medicare beneficiaries under the Medicare+Choice program. He has also been involved in the HIPAA and Medicare MSA demonstration evaluations. Additionally, he has conducted analyses estimating costs of legislative and regulatory proposals in public and private markets for health insurance on national and state budgets, households, and businesses. Additional areas of experience include Medicaid managed care, medical liability (tort) reform, patient protection initiatives, and the market for employer-sponsored health insurance and has scored specific legislation at both the federal and state levels. He is currently pursuing a Master of Health Science (MHS) in Health Policy at the Johns Hopkins School of Hygiene and Public Health.

Raymond B. Werntz, Jr., is President of the Consumer Health Education Council (CHEC). Previously, he was Vice President, Compensation and Benefits, for Whitman Corporation, Rolling Meadows, IL (a multi-billion dollar international company emphasizing soft drinks and consumer products). His responsibilities included human resources programs and services for Whitman and its domestic and international subsidiaries covering approximately 18,000 employees worldwide that linked employee performance and profitable business growth through improved program design, financing, administration, data analysis, and innovative employee education. Werntz is a frequent speaker on topics ranging from public- and private-sector health policy to human resources information strategies. He is a member of the Steering Committee of the Chicago Business Group on Health and the Health and Medicine Policy Research Group, the Worksite Wellness Council and the Chicago Health Policy Research Council, as well as other organizations addressing general health policy, custodial care, medical indigence, and mental health. Werntz received his B.A. and M.A. from DePaul University and J.D. from John Marshall Law School. He is a member of the American, Illinois, and Chicago Bar Associations.

Executive Summary

by Stephen Blakely

For better or worse—depending on your perspective—health insurance in the United States is tied to employment: Two-thirds of all those under age 65, amounting to 151.7 million Americans, currently get their health care coverage through an employer. Health insurance is the benefit most used and valued by workers and their families, surveys show.

This "employment-based" health insurance system, as it has evolved since World War II, has developed a bewildering combination of advantages and drawbacks. For example, employers are generally able to get lower insurance premiums than individuals because there is less adverse selection, average administrative and marketing costs are lower, and they can negotiate discounts for providing a large volume of patients. On the other hand, workers who change jobs usually must also change doctors, and self-employed workers and others who must buy individual health policies do not enjoy all of the tax preferences bestowed on those inside the employment-based system. Also, some workers are forced into "job lock" with their current employers just to maintain health coverage.

The most visible drawback with the voluntary system of health insurance, however designed, is the 43 million Americans who have no health insurance (although employment-based insurance is frequently cited as "the problem," any voluntary system will include substantial noncoverage). Unlike in many developed nations, where health care is universal and funded by the national government (at great expense), health insurance in the United States is voluntary: Employers—whether they be corporations, unions, governments, or nonprofits—are not required to offer health insurance to workers and their families. While virtually all large employers offer it, many small employers do not. As a result, about 18 percent of the U.S. population is uninsured because their jobs do not provide health care coverage or they have declined the coverage that is offered.

Some policymakers and interest groups advocate severing the link between health insurance and employment, through either incremental or fundamental changes in the federal tax code—a move that could dramatically affect the more than $259 billion in annual health insurance costs that employers currently pay on behalf of their workers. Most proposals involve new tax credits for those who buy health insurance in the individual market, so as to reduce the number of uninsured and expand individuals' choice of health plans without rupturing the employment-based system.

But what would happen if the link between employment and health benefits were broken? Would "adverse selection" transform the economics of health insurance and ultimately drive the market into a "death spiral" of ever-increasing health insurance premiums? Would fewer Americans be covered by private health insurance and would government-financed universal coverage result? Would health care coverage and quality improve? And what would the American public support?

Leaders of the health care industry, the benefits sector, unions, employers and legislators examined these questions during the Employee Benefit Research Institute-Education and Research Fund's May 5, 1999, policy forum on "Severing the Link Between Health Insurance and Employment." Attended by more than a hundred invited experts, and funded by the Robert Wood Johnson Foundation, the policy forum examined the link between health insurance and employment, how various federal policies might put that link at risk, and what the implications of those policies might be for workers, employers, and the government.

As UCLA professor and health economist Tom Rice pointed out, there are no easy answers. "I'm very sympathetic to the overall notion that most of our problems in our health care system

stem from the linkage between employment and insurance," Rice told policy forum participants. But he also said: "I'm concerned these [structural reform] proposals might lead to more uninsured, more two-tier medicine, and less preventive services without necessarily controlling health care costs."

■ Public Opinion

Ultimately, the success or failure of proposals to change the tax treatment of health insurance depends on the public's reaction. Since any change in the tax preference for health benefits may affect the real price of health insurance, it is important to understand how the public currently feels about employment-based health insurance, alternatives to the employment-based system, and changes to the tax code.

To help gauge these issues, the Employee Benefit Research Institute, in conjunction with Mathew Greenwald & Associates, conducted a public opinion survey in early 1999 on public attitudes toward health insurance. The Health Insurance Preference Survey examined the level of public satisfaction with the current system, individual preference for the employment-based health insurance system, and individual preference for an individual-based system that would require people to find and obtain health coverage on their own without job-based health coverage. Among the survey's key findings:

- Sixty-eight percent of Americans with employment-based health insurance were satisfied with the current mix of benefits and wages.
- Twenty percent of respondents reported that they preferred *higher* health benefits and *lower* wages.
- Eight percent reported the opposite preference—for lower health benefits and higher wages.

"Most people are pretty satisfied with the current mix of benefits and wages," said Paul Fronstin, EBRI senior research associate. "Most people are pretty confident in their employer's ability to choose the health plan."

The Health Insurance Preference Survey also examined who might opt out of the employment-based system, first by questioning respondents about a proposal that would simply "delink" health insurance from employment by giving workers higher income that could be used to purchase health insurance on their own. A second question was geared toward determining whether individuals would opt out of the employment-based system if health insurance benefits were subject to taxes.

Under both questions, respondents were asked whether they would prefer that workers continue to get health insurance as a benefit through employers, or alternatively receive higher wages and purchase health insurance coverage on their own. Under the scenario where the tax code is unchanged, 75 percent of respondents said they preferred that workers continue to get health insurance through the employer. Twenty percent would prefer a higher wage to purchase health insurance on their own.

Even if the existing tax exclusion for employment-based health insurance were removed, the survey still found strong support for the employment-based system, although support for higher wages to purchase health insurance in the individual market doubled, increasing from 20 percent to 40 percent.

The survey also found that men are more likely than women to have a strong preference for an individual-based health insurance system, and older persons are more likely than younger persons to strongly support the employment-based system and less likely to support an individual-based system. Persons dissatisfied with their health plan would be more likely than satisfied persons to opt out of the employment-based system.

■ Tax Treatment and the Uninsured

The basic purpose of employers offering health benefits to their workers is to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified employees.

Currently, health insurance premiums paid by employers are deductible for employers as a business expense, and are also excluded, without limit, from workers' taxable income (this tax exclusion amounted to an estimated $111 billion in 1998). In contrast, the self-employed were able to deduct only 45 percent of the amount paid for health insurance during 1998, although under

current law that percentage will gradually increase to 100 percent by 2003. Also, for individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income, and only the amount that exceeds 7.5 percent of adjusted gross income is deductible.

The tax preference for employment-based health insurance is generally viewed as being regressive, since workers in higher tax brackets receive greater tax advantages in dollar amounts than those received by lower-paid workers. However, when measured as a percentage of income, the exclusion represents greater savings for lower-income workers than for higher-income workers.

William Custer, a professor at Georgia State University, noted that the tax exclusion for employer-paid health insurance premiums amounts to "a subsidy for the purchase of health insurance for those individuals receiving coverage through the work place," and is the largest single tax "expenditure" (in terms of revenue forgone) in the federal budget. Traditional economic arguments, he noted, contend that the existing tax preferences for employment-based health insurance tend to cause healthy workers to purchase too much health coverage, which "distorts the market for health insurance and therefore creates an inefficient allocation of resources."

However, in an analysis prepared for the policy forum, Custer argued that the federal tax subsidy is not the only reason why the health insurance market is inefficient, and that the current tax subsidy is of most benefit to those who are low income and in poor health. Moving from an employment-based to an individual-based health coverage system would be likely to result in higher rates of uninsured, he said, especially among those in poor health who would probably be unable to afford the higher insurance premiums that would come with individual-based risk rating.

"If you want to have a wide distribution of health insurance coverage and a voluntary system—that is, individuals choosing where and how to buy coverage—you cannot get it without the employment-based system. The individual market cannot provide that subsidy," Custer said. "If you want a voluntary system, you have to go through the employer."

One of the biggest concerns with removing the existing tax subsidy for the employment-based health insurance system is adverse selection—a situation where healthy, low-risk participants drop coverage and only the high-risk, unhealthy participants remain, thereby forcing premiums to go up and ultimately making the health plan unsustainable. One possible way to avoid that, advocates say, would be to replace the current employment-based system with one involving capped refundable tax credits—a dollar-for-dollar tax refund to individuals for the cost of their health insurance, up to a certain limit (or cap).

This approach appears to be viable, according to a study conducted by Thomas Selden of the Agency for Health Care Policy and Research, and Bradley Gray of Tulane University. Their analysis focused on the Federal Employee Health Benefits Program, since that plan has a capped subsidy system. While their conclusions are not definitive, Selden noted, their results suggest that, in the context of an employment-based system, a capped, refundable tax credit "could reduce excessive medical care, avoid adverse selection, and increase quality."

However, additional research presented by Kenneth Thorpe, head of health policy and management at Emory University's Rollins School of Public Health, concluded that the federal government would have to provide an extraordinarily generous tax credit in order to significantly reduce the number of uninsured. Thorpe's analysis indicates that even if the full cost of individual health insurance were covered by tax credits, only 75 percent to 80 percent of uninsured Americans would obtain coverage.

"In order to get people to buy [health insurance] who don't have it, you have to provide a very substantial subsidy," Thorpe said.

Would a shift away from employment-based coverage to an individual health insurance market necessarily increase the number of uninsured—and if so, how much? Research presented by Donald Cox and Christopher Topoleski of the Barents Group LLC suggests it probably would, and possibly by a lot, although it is impossible to say for sure.

Their analysis of legislative initiatives aimed at individual health insurance choice involved a hypothetical law that eliminated the

current health tax exclusions for both individuals and corporations and implemented refundable tax credits for individuals purchasing health insurance on their own. Based on Census Bureau and other data, their results suggest a very wide range of possible changes in health insurance coverage, depending on how much of a subsidy is provided by the tax credits and how affordable health insurance is under an individual system.

"You're going to see, at best, a negligible effect on the uninsured, but at worst perhaps you're going to see a substantial increase," Cox said. He urged "extreme caution" in projecting results from individual initiative proposals in Congress because of the "complex interactions and huge amount of uncertainty in how individuals are going to behave."

■ Alternatives to the Employment-Based Health System

For all the different reform proposals, there are two basic approaches to creating an alternative to the existing U.S. health insurance system, according to Stuart Butler, vice president of domestic and economic policy studies at the Heritage Foundation:

- *Structural change,* in which the tax laws are fundamentally transformed to eliminate the current tax exclusion and provide coverage in a different way through refundable tax credits, which would be available for use against all medical expenses. Although this would be budget-neutral to the federal government, Butler said, it would not be likely to cover all the uninsured, and additional subsidies would be needed.
- *Incremental change,* aimed at reducing the number of uninsured by providing a tax credit exclusively to people who do not have employment-based coverage. Butler describes this as a "much more targeted kind of approach" that would maintain the current system while allowing those who cannot get health coverage through their jobs to get access to other kinds of insurance pools or health plans. This would be likely to cost the federal government more than it is spending now, he said.

UCLA's Tom Rice identified several advantages to structural reform: It would provide more equitable and progressive tax treatment to Americans, regardless of their employment status; it would provide more help to those who spend a larger share of their income on health insurance; it would end job lock; and it would expand individuals' choice of health plans.

But there are some serious disadvantages as well, Rice warned: the likelihood of higher costs and less affordability of health insurance; "two-tier medicine" and poor care for lower income people; a probable reduction in preventive care, a hallmark of employment-based managed care plans; and an incentive for employers to drop health coverage during economic downturns.

Butler argued that the uninsured is the crucial problem that has to be addressed. "The whole issue of severing the link between health insurance and employment is not a matter of discussion for millions of uninsured Americans. They're not in the employment-based system at all," Butler said. "The issue is, how do we take some steps to provide them with some alternative to the employment-based system that they don't currently have?"

In outlining some of the Heritage Foundation's proposals, Butler argued it is possible that the current system can be structurally changed to provide more equitable tax treatment without turning large employment-based health plans into "dinosaurs." One option, he suggested, would be to deny a tax credit to individuals who "opt out" of health care coverage offered through their job in order to save money. Butler also argued that the current debate over the U.S. health insurance system represents evolutionary—and not "revolutionary"—change that will inevitably need to be refined.

"The tax changes that we're talking about are not designed to be a perfect solution," he said. "They're designed to take the $100 billion tax subsidy that we currently have and make it more equitable and sensible."

For the nation's doctors, the ever-growing number of uninsured is only one sign of failure in the nation's employment-based system. As employers have embraced managed care plans in recent years to clamp down on rising health benefit costs, doctors have found themselves squeezed both by insurance restrictions on their medical treatment authority and by a loss of income. As a result, managed care restrictions on health benefits have

provoked a backlash among doctors as well as their patients, which in turn has elevated the patients' rights movement into a potent political force in Congress and many state legislatures.

"Americans' confidence in the future of the employer-based system is eroding," said Dr. Nancy Dickey, president of the American Medical Association (AMA) and a family physician from College Station, TX. "Our reliance on an employer-based system of health benefits in the United States needs to be reconsidered."

The AMA has proposed a three-point plan that calls for replacing the current tax exclusion for employer-provided health benefits with an individual tax credit for health insurance premiums; reducing the growing number of state health mandates and increasing new risk-pooling alternatives to job-based insurance pools; and shifting to a defined contribution approach to health benefits, to give employees more of a choice in health plans.

Dickey said the AMA's proposal would shift the role of employers "from the foreground to the background," and "increases substantially employees' freedom and authority to make their own decisions regarding their health care coverage." She also said the AMA's proposal would not "dismantle" the current employment-based system.

Presenting policymaker views at the policy forum were Reps. Benjamin Cardin (D-MD) and Rep. John Shadegg (R-AZ), both of whom have been active in health policy legislation. Both lawmakers expressed a desire to maintain the employment-based insurance system, although Cardin voiced support for universal coverage through incremental changes, while Shadegg supported tax credits. On the day of the policy forum, Shadegg introduced H.R. 1687, the Patients' Health Care Choice Act, which would provide a capped, refundable tax credit that he said would give tax equity to Americans who cannot get health insurance through an employer.

■ Insurer Response to a Changing Market

Whatever the deficiencies in the employment-based health insurance system, insurance companies see a lot of danger—for everyone involved—in shifting to an individual insurance market. Just some of the major concerns that insurers have:

- *Risk pooling and adverse selection.* Since employers provide a so-called "natural group" for risk pooling (not formed for the specific purpose of insurance), they include a workable mix of healthy and unhealthy individuals, which in turn makes it possible to successfully manage the risk. On an individual basis, the ability to pool risks is more difficult, more expensive, and might not be economically viable.
- *Cross-subsidy.* Under the current system, low-risk individuals help subsidize the cost of the high-risk individuals because they are part of a larger employment-based group. In an individual insurance market, this cross-subsidy would be likely to collapse, creating social and economic conflicts between young and old, wealthy and poor.
- *Administrative costs.* Because employers enroll groups (and sometimes very large groups) of participants in a health plan, the per capita cost of underwriting and managing individuals in the plan is relatively low. By contrast, individual policies are far more expensive to underwrite and administer—a major reason why individual health policies have higher premiums.
- *Government response.* If the existing tax preferences for health insurance were abolished, would the new individual-based system get the same amount of tax preferences, or less? Many carriers suspect that if the number of uninsured or health insurance costs shoot up, state and federal governments may force them to offer coverage to bad risks ("guaranteed issue," as it's called) or impose a flat-rate premium for all ("community rating").

Mary Nell Lehnard, senior vice president for policy and representation at the Blue Cross and Blue Shield Association, warns "the mother of all issues is whether it's possible to create a stable system for pooling risks in the individual market. Who's going to be willing to subsidize whom?" She sees a danger of "intergenerational warfare, with different age groups lobbying Congress to lower their premiums at the expense of other age groups, especially young versus old."

Lehnard also pointed out that because the individual market is high-risk for insurers, state regulators would force them to sharply increase

their financial reserves and capitalization levels to cover expected losses and unpaid claims when carriers go out of business. "We estimate that roughly $30 billion in additional capital would be needed to capitalize all of the individual market insurance businesses," she said. "That's a huge accumulation of cash."

Because of the regulatory issue alone, the U.S. insurance industry would not currently be able to shift from the employment-based system to an individual market, according to Carl Scott, director of individual marketing for Mutual of Omaha. The company is the largest commercial insurance carrier in the individual major medical marketplace, Scott added.

"Currently, there is not sufficient capacity in the individual marketplace to absorb all the people who would fall out of a group environment. Just isn't there," Scott said. "Under the current rules, reserve requirements, state insurance regulations, all the things that have to be done to manage the fairness and equity of the individual pool, it isn't possible."

Scott pointed out that over-regulation has forced Mutual of Omaha to withdraw the sale of individual major medical policies from eight states in the past eight years, because state-imposed restrictions have made it impossible for the company to effectively manage the risks. He also said one of the best ways to expand and strengthen the individual health insurance market would be to "eliminate the 900-plus health mandates that the state insurance departments have applied to the individual market."

However, if tax preferences were ended for the employment-based system, both insurance carriers and state regulators would find ways to reduce costs and improve efficiencies in the individual market, according to Dwight Bartlett, III, of the American Academy of Actuaries. For instance, insurers would be likely to reduce their commissions for the sale of individual policies, adopt simplified underwriting and rating procedures, and avoid doing expensive medical exams, he said, while regulators would try to streamline regulatory procedures and develop standardized benefit packages.

Bartlett predicted that state regulation of insurance would have to be sacrificed in any major shift to an individual health insurance system. "We're more likely to have a stable and viable market, in fact, if there is federal pre-emption of state regulation," he said.

■ Employer Responses

For employers who sponsor health plans for their workers, and who collectively spent an estimated $259.4 billion on group health insurance costs for their employees in 1997, the prospect of shifting to an individual-based insurance system has an obvious attraction.

"If there were magic wands, I can't think of an employer who wouldn't love to have the whole issue of sponsoring health benefits go away. Their vote would be, 'If fairy tales would come true, we're out of this game,'" said Kenneth Jacobsen, senior vice president for the Segal Company, who has more than two decades of experience in the health benefits field. "But I don't think that's the way it's going to be."

Jacobsen recited the traditional reasons why employers sponsor health plans (recruiting and retention, maintaining productivity, the tax benefits, a sense of paternalism), as well as the drawbacks (high costs, widespread dissatisfaction with managed care, regulations, and red tape). He noted that employers are concerned about the uninsured, too, especially since the health insurance premiums they and others pay wind up subsidizing most of the cost of treating uninsured patients.

Employers also play critically important but largely unappreciated roles that help both workers and insurance companies, Jacobsen added. They act as an "agent" for both consumers and insurers, negotiating fees, designing and enforcing quality and service agreements with managed care plans, ensuring that workers have access to local specialists, and transmitting workers' insurance premium payments to insurers through regular payroll deductions.

Jacobsen argued that both employers and their workers stand to lose if the existing employment-based insurance system is eliminated: Employers would lose a critically important hiring and retention tool, while workers would probably see a one-time pay boost, higher insurance premiums, and poor coverage for those with health problems. "And nobody is going to escape higher

taxes if we take this system and revamp it," he predicted.

Ray Werntz, president of the Consumer Health Education Council, suggested employers—especially large ones—get far more value out of offering health benefits than just tax benefits. In particular, he said, providing health coverage for workers is essential to maintaining a company's productivity and competitiveness and also maintains the employer's ability to control costs and quality in the health benefits sector.

Among small businesses, which are often at a disadvantage in the employment-based health marketplace because of their small size and limited revenues, the potential advantages of making fundamental changes are viewed with skepticism.

Victoria Caldeira, of the National Federation of Independent Business, noted that NFIB's small-business members "desperately want more choices in the marketplace and better value for the dollar when it comes to purchasing health care." Nevertheless, she added, NFIB members "are not willing to give up the benefits of our current system." NFIB's proposals involve an expansion of small-business insurance pools through interstate association health plans, greater deductibility of health insurance for the unemployed and those without employment-based coverage, and opposition to health care mandates.

■ Implications

With the health insurance of 152 million Americans at stake, the prospect of restructuring the U.S. health insurance system instills fear in some experts and excitement in others. As expressed by Robert Helms, director of health policy studies at the American Enterprise Institute, the demise of the current system "will be for the national good" over the long run, despite the probable "rocky" transition.

By contrast, Deborah Chollet, vice president at Alpha Center, stressed the importance of minimizing disruption of the employment-based system by carefully designing any tax credits for individual-based insurance coverage. "I would warn against leaps of faith in an age of wonders," she said.

One recurring point that emerged is that federal tax policy, as set by Congress, is crucial to the future of the American health insurance system. In closing comments at the policy forum, Merrill Matthews, Jr., director of health policy studies at the National Center for Policy Analysis, argued that a tax credit for individually purchased health coverage would be better than the current tax treatment, if the credit is neither too generous nor too limited. "The goal should be to minimize the number of uninsured, maximize choice and freedom in a system that is consistent with the American economic system and American values," Matthews said. "What kind of tax break does that? I would argue the tax credit."

However, Len Nichols of the Urban Institute noted that for all the different opinions on health insurance, "no one is talking about completely abolishing *all* tax preference, but instead changing the *nature* of it." That, he said, demonstrates a consensus on the need to subsidize health insurance. Nichols said the positive aspects of the employment-based system that need to be retained are the economies of scale in purchasing and administering health insurance to groups.

Another recurring point raised by several speakers was the need to be careful and guard against unexpected consequences—especially with health coverage for millions of people potentially in the balance.

EBRI President and CEO Dallas L. Salisbury concluded the session by noting: "The employment-based system is not perfect, but it has helped to rationalize the payment and delivery of health care for a large majority of individuals and households in a voluntary system. The use of 'natural' groups helps in administration, cost management, communication with the insured, and much more. The glass, if you will, is more than 80 percent full. The early American system of health finance was individually based, and back then the glass was nearly empty."

Salisbury noted that group insurance, facilitated by employers and unions, grew from natural market forces to extend efficient coverage. While technology may now provide means of forming alternative groups, and individuals may have the means of more effectively gaining information and making choices, change must be considered with great care, he said.

"The stated objective of all parties is to expand the number of Americans with health insurance. We must make certain that policy change leads to this result, not to an unintended consequence of lower coverage. As the policy forum presentations pointed out, such unintended consequences are a true risk of policy change."

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Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion

by Paul Fronstin

Introduction

Employment-based health plans are the most common source of health insurance among nonelderly individuals in the United States, providing coverage to nearly two-thirds of this population in 1997 (chart 1.1). In addition, 34 percent of individuals ages 65 and older had employment-based coverage in 1997, mainly as a supplement to Medicare (Fronstin, 1998b). The basic purpose for employers offering employment-based health benefits is to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. Health insurance is probably the benefit most used and valued by workers and their families. Sixty-four percent of respondents to a recent survey rated employment-based health insurance benefits as the most important benefit (Ostuw, 1996).

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase for several reasons. When wages were frozen by the National War Labor Board and there was a shortage of workers, employers sought ways to get around the wage controls in order to attract scarce workers, and offering health insurance was one option. Health insurance was an attractive means to attract and retain workers during a labor shortage for two reasons: Unions supported employment-based health insurance, and workers' health benefits were not subject to income tax or Social Security payroll taxes, as were cash wages.

Twelve million people (less than 10 percent of the population) were covered by private health insurance in 1940. By 1945 when the war ended, 32 million people (approximately 23 percent of the population) had private health insurance coverage, and by 1950, 77 million (approximately 51 percent) had

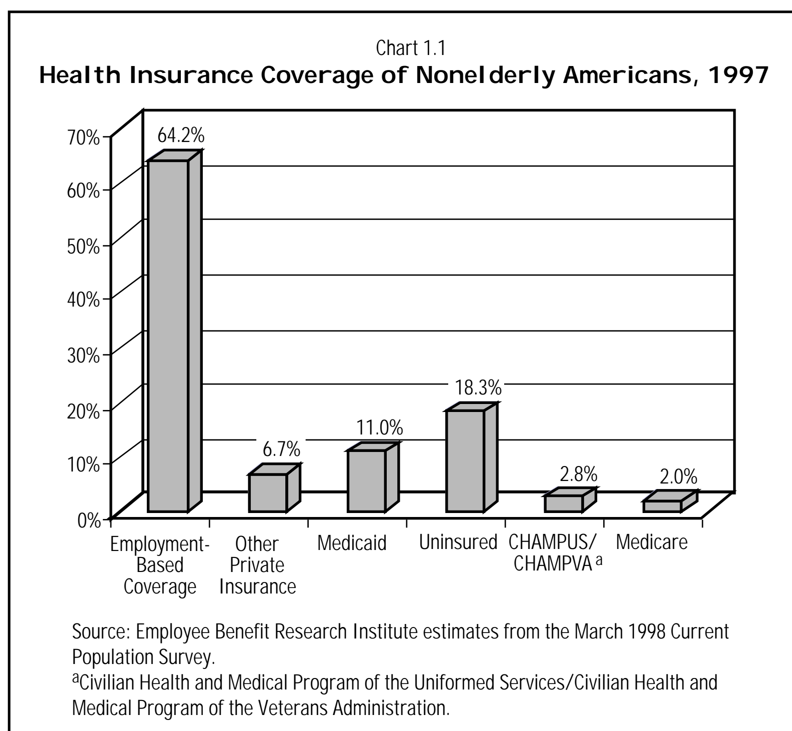
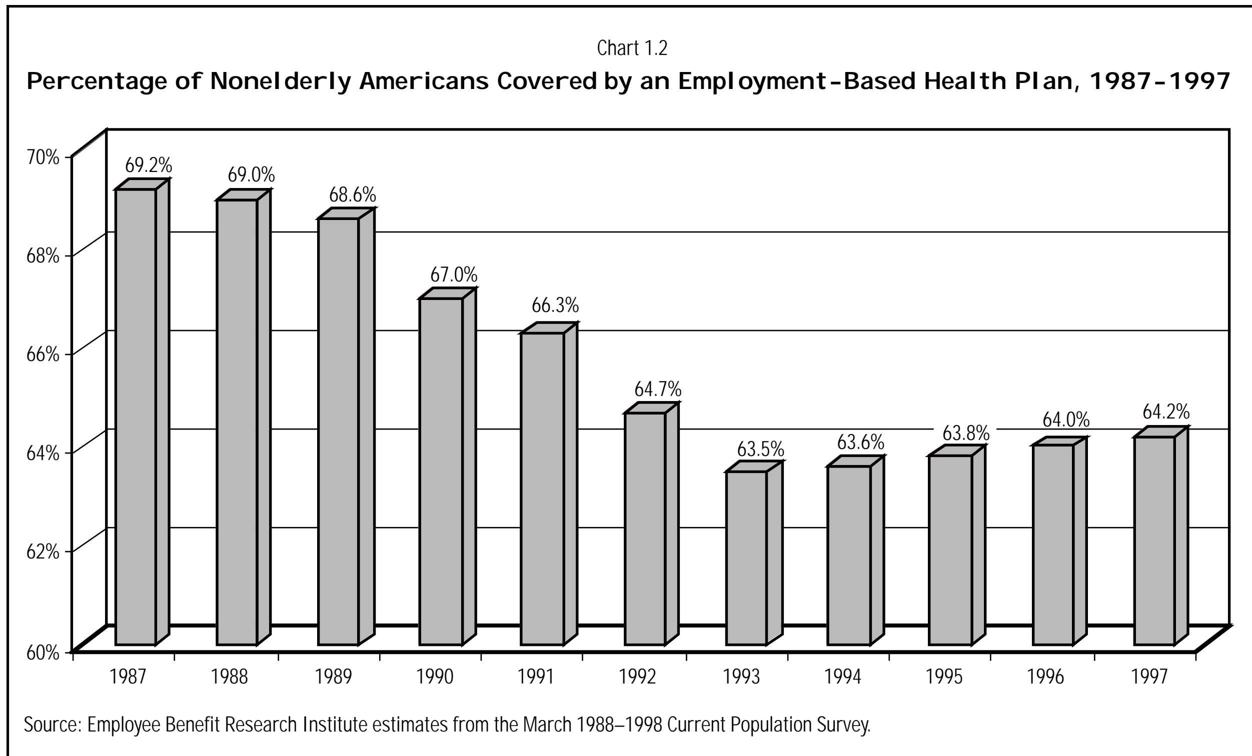


Chart 1.1
Health Insurance Coverage of Nonelderly Americans, 1997

Source: Employee Benefit Research Institute estimates from the March 1998 Current Population Survey.
[a]Civilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration.



such coverage (Health Insurance Association of America, 1996). In 1997, nearly 168 million nonelderly Americans (71 percent of the U.S. population) were covered by private health insurance, and 151.7 million of these individuals (just over 90 percent of those with private coverage) had employment-based plans (Fronstin, 1998c). While the number of Americans covered by employment-based health plans expanded between World War II and the 1980s, coverage levels fell in recent years from the record-high level reached during the 1980s (69.2 percent of the nonelderly population in 1987) to 63.5 percent in 1993 (chart 1.2). This decline was due in large part to rising health care costs, but the changing labor force also contributed to the decline.[1] Since 1993, employment-based coverage has been increasing—partly due to downsizing in the military, efforts to move individuals from welfare to work, and the strong economy—and it now includes 64.2 percent of the nonelderly population.[2]

It should be noted, however, that the percentage of nonelderly Americans with employment-based coverage, while increasing in recent years, has not yet reached the level it attained in 1992. Despite essentially five years of very low health care cost increases and the recent increase in the percentage of Americans with employment-based health insurance coverage, the percentage of Americans who are uninsured has continued to rise, although the rate of increase has slowed. It appears that individuals leaving welfare (and Medicaid) are contributing to the increase in the uninsured population, although they are also likely contributing to the increase in the number of individuals receiving employment-based coverage. The continued rise in the uninsured has resulted in a new interest among policymakers and policy analysts in finding ways to reverse this trend.

One question that continues to be asked is whether the employment-based health insurance system is the appropriate mechanism for expanding health insurance to the uninsured. Many

[1] According to Fronstin and Snider (1996/97), the movement of workers into part-time jobs, nonunionized jobs, and service jobs, as well as declining real income, also contributed to the decline in employment-based health insurance.

[2] Much more research needs to be conducted to truly understand the recent dynamics among employment-based health insurance coverage, welfare, and the uninsured in the last few years.

policymakers and policy analysts believe it is not, while others believe it is.

This discussion provides background information on the employment-based health insurance system and its alternatives. (In addition, it presents data from a recent public opinion survey on attitudes toward the employment-based health insurance system and its alternatives, and summarizes papers that have examined the effects of tax reform on employment-based health insurance and the uninsured.) It examines the advantages and disadvantages of the current employment-based health insurance system, the current tax treatment of health insurance, and the strength and weaknesses of recent proposals to introduce tax credits. It presents findings from the public opinion survey conducted by the Employee Benefit Research Institute on public attitudes toward health insurance and summarizes recent research on the effects of tax changes on employment-based health benefits and the uninsured. The final section presents conclusions.

■ The Current System

Greatly simplified, the purpose of any insurance system is to create an economically sustainable way to spread the risk of loss across high-risk and low-risk individuals. In the case of private health insurance, employment-based health plans are the major source of coverage in the United States today. These plans are popular because they offer many advantages over other forms of health insurance and types of delivery systems. However, there are also potential drawbacks to the employment-based system, some of which are discussed in this section.

Among the Advantages:

Adverse Selection—Adverse selection exists when a disproportionate number of unhealthy individuals are enrolled in a specific health plan. In other words, a health plan may suffer from adverse selection when unhealthy individuals are more likely than healthy individuals to enroll in the plan. In a purely voluntary system, such as the U.S. system, the risk of adverse selection is relatively high. In order to reduce adverse selection, insurers often seek to enroll groups of individuals rather than the individuals themselves; even though they are not able to single out higher-risk or unhealthy individuals in the group, they often get the good risks along with the bad risks. When it comes to insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. Therefore, employment-based health insurance is a potent means for spreading risk among healthy and unhealthy individuals.

Group Purchasing Efficiencies—The existence of economies of scale in the purchase of group health insurance coverage results in a lower average premium. When economies of scale exist, the average administrative costs of insuring a group make up a smaller percentage of the cost of health insurance. As a result, large firms that are able to exert market power are more likely to offer health benefits than small firms because they can purchase the same plan at a lower cost. In addition, employers may be better at finding or negotiating for lower-cost health plans than workers would be in the individual market.

Employment-based health insurance has both positive and negative effects on the labor market. It benefits employers because it encourages workers to keep their jobs, thereby reducing "quit rates" and turnover costs. However, this form of insurance puts workers at a disadvantage because health benefits are not portable from job to job, which is a major cause of "job lock," as discussed below.

Employer as Advocate—Employers are not only able to find or negotiate lower health insurance costs than workers can in the individual market, they also often act as advocate for workers during coverage disputes between the insured and the insurer. For example, an employer experiencing widespread dissatisfaction with a specific health plan will either find a new health plan or threaten to find a new health plan if the insurer does not respond to the issues raised by the plan's members. Insurers are more likely to respond to an employer than to an individual because of the risk of losing a

large group contract covering individuals who are not adversely selected.

Delivery Innovation and Health Care Quality—Employers frequently become involved in health care quality assessment and policy development. Large employers began to pay closer attention to health care quality when costs rose sharply in the 1970s and 1980s. One result was the formation of employer coalitions for the purpose of sharing information about quality that would enable members to contract with the best insurers and providers. Many believe that employers are better able to monitor quality of health care than individuals.

Among the Disadvantages:

Tax Treatment May Be Unfair—Under current tax law, individuals who receive health insurance benefits through the work place pay no taxes on the benefits received. Alternatively, those who purchase health insurance directly from an insurer are not able to deduct the cost of the insurance from taxable income.[3] As a result, there are real differences in the cost of employment-based vs. individual health insurance that are not attributable to differences in benefits. For example, an individual purchasing health insurance through an insurer would not receive the same tax benefits as one covered through the work place. Similarly, the self-employed are currently able to only partially deduct the cost of their health insurance. Extending the tax break to individuals who purchase health insurance on their own might encourage uninsured individuals to purchase health insurance on their own.[4]

Job Lock—Currently, health insurance is not usually portable from job to job, i.e., workers cannot usually continue to participate in their health plan when they change jobs.[5] As a result, they often remain with current employers for a number of reasons related to employment-based health insurance: A prospective employer may not offer health insurance; the worker may have to change doctors when changing health plans; a waiting period may be required before the worker becomes eligible for coverage;[6] and the benefits package offered through the prospective employer may be less generous than the worker's current benefits. These scenarios may result in job lock—employees forgoing job opportunities that could potentially increase their productivity and income, in order to preserve existing health insurance benefits. Portability of health insurance could help alleviate the loss of health benefits when a worker is offered a new job.

Little Choice of Plans—Currently, very few employers offer a choice of health plans.[7] However, the 1998 Health Confidence Survey conducted by the Employee Benefit Research Institute and Mathew Greenwald & Associates found that workers with a choice of health plans were more satisfied with their health benefits than those without a choice. Specifically, 56 percent of individuals with a choice of plans were either extremely or very satisfied with their current plan, compared with 43 percent

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[3] Individuals can deduct the portion of health care expenses (including health insurance premiums) that exceed 7.5 percent of adjusted gross income if they itemize their deductions. The number of individuals claiming this deduction is quite small and has been declining as a percentage of the number of returns filed (Internal Revenue Service, 1999).

[4] It may also induce those already covered to purchase more generous coverage.

[5] The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows workers at their own cost to continue their health benefits on job change, but only for 18 months. In addition, the premiums that a person pays toward COBRA are usually not excludable from taxable income as are premiums that employers pay toward a worker's health benefits.

[6] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prevents employers and insurers from imposing pre-existing condition exclusions for individuals with a history of prior health insurance. Employers and insurers may still require that workers fulfill a waiting period before becoming eligible for any health benefits.

[7] A recent survey of employers conducted by the RAND Corporation found that only 17 percent of employers offered their workers a choice of health plans. However, the 1999 Health Insurance Preference Survey conducted by the Employee Benefit Research Institute found that 59 percent of adults covered by an employment-based health plan were allowed to choose from more than one plan.

Table 1.1
Value of Exclusion of Employer Contribution of $3,000 to Four Families of Different Income Levels, A Simple Illustration

	Family Income	Cost as a Percentage of Income	Marginal Tax Rate	Value of Exclusion	Exclusion as a Percentage of Income
Family 1	$ 12,000	25%	0%	$ 0	0%
Family 2	20,000	15	15	450	2.3
Family 3	50,000	6	28	840	1.7
Family 4	100,000	3	31	930	0.9

Source: Employee Benefit Research Institute calculations.

who were either extremely or very satisfied with their current plan among individuals without a choice of plans. Even when employees do have a choice of plans, they may have a choice of only two or three plans.[8] Individuals might have a greater array of health insurance choices if insurance were not tied to employment.

Lack of Universal Coverage—More than 43 million Americans, or 18.3 percent of the nonelderly population, were uninsured in 1997 (Fronstin, 1998c).

In a purely voluntary system such as the employment-based system in the United States, it is nearly impossible to achieve universal coverage. Many small companies choose to not provide health benefits,[9] and many workers choose to forego benefits when they are offered.[10] The absence of universal coverage has implications for worker productivity; the health of the population; access to health care; and the cost of health care and health insurance for the insured population and third-party payers of health care such as insurers, employers, and the public sector.

■ Current Tax Treatment

Currently, health insurance premiums paid by employers are deductible for employers as a business expense, and are also excluded, without limit, from workers' taxable income. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for health care expenses with pretax dollars—meaning, they are not taxed on the amount of money that is put into the FSA. In contrast, the self-employed were able to deduct only 45 percent of the amount paid for health insurance during 1998.[11] Furthermore, for individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income, and only the amount that exceeds 7.5 percent of adjusted gross income is deductible.

The tax preference for health insurance is generally viewed as being regressive, although some analysts would argue that it could be viewed as progressive, depending on how the numbers are analyzed.[12] In dollar amounts, the tax exclusion can be viewed as regressive because it benefits higher-income individuals more than lower-income individuals. The regressive tax structure enables workers in higher tax brackets to receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because, although the value of the benefits is generally the same for all workers with the same employer regardless of income, higher-income

[8] *However, the two or three plans chosen by the employer could be the best plans available in the area.*

[9] *In 1998, 46 percent of firms with 200 or fewer workers did not offer health benefits (Gabel et al., 1999).*

[10] *Cooper and Schone (1997) found that 29.1 percent of uninsured workers had access to an employment-based health plan, either through their own employer or through their spouse's employer.*

[11] *Under current law, the self-employed will be able to deduct 100 percent of the cost of their health insurance beginning in the year 2003.*

[12] *Under a progressive tax system, marginal tax rates increase with income (Varian, 1987). However, a flat tax system may be progressive if income up to a certain level is exempt from taxes.*

workers face a higher marginal tax rate.[13] Table 1.1 illustrates the value of the health insurance tax exclusion to families with different income levels who work for the same firm. Under the current tax rate structure, the first family in table 1.1 faces a 0 percent marginal tax rate, while the marginal tax rates for the second, third, and fourth families are 15 percent, 28 percent, and 31 percent, respectively. If the employer contributes $3,000 for each family, the absolute reduction in taxes attributable to the health insurance tax exclusion would be worth: $0 to a family with income of $12,000; $450 to a family with taxable income of $20,000; $840 to a family with taxable income of $50,000; and $930 to a family with taxable income of $100,000. Thus, the tax exclusion is worth twice as much to families in the 31 percent tax bracket as it is to families in the 15 percent bracket in dollar amounts, and nothing at all to the lowest-income family.

However, for workers who receive employer contributions to their health insurance coverage, some analysts could make the argument that the exclusion may also be viewed as progressive. As a percentage of income, the exclusion represents greater savings for lower-income workers than for higher-income workers (Institute of Medicine, 1993). Again looking at table 1.1, if the employer contributes $3,000 for each family's health insurance premium, the tax preference would equal: 2.3 percent of the income of the family earning $20,000; 1.7 percent of the income of the family earning $50,000; and 0.9 percent of the income of the family earning $100,000. Thus, the table shows that, while the exclusion is greater in dollar amounts for the families with higher incomes, as a percentage of income, the value of the exclusion falls as income rises. When examining the tax exclusion by percentage of income it should be noted that it is not progressive at all income levels. Individuals with income of $12,000 receive no tax exclusion because they pay no taxes. A refundable tax credit would result in a reduction in taxes for these families.

■ Tax Credit Issues

The current tax code is often criticized as contributing to the uninsured population.[14] As a result, proposals to expand health insurance coverage through a tax credit have been receiving increased attention lately.[15] The tax credits proposals for health insurance, which come in all shapes and sizes, as seen in table 1.2, would either enhance the current employment-based health insurance system or put it at risk.

Reps. Dick Armey (R-TX) and Pete Stark (D-CA), in a recent editorial advocating health insurance tax credits, said the concept would "unavoidably" prompt some employers and employees to drop work place coverage. "But job-based coverage is already eroding," they said, although both support the continuation of the employment-based system as one option for obtaining health insurance.

One possibility is to replace the current tax exclusion with a tax credit for all persons with health insurance. Rep. Bill Thomas (R-CA) has been discussing replacing the employer deduction for health insurance with an individual tax credit. If the tax credit were refundable, all persons with the same health insurance coverage who claim the credit would get the same tax credit.[16] Another possibility is to leave the tax exclusion unchanged for individuals who get insurance through employment and add a refundable tax credit solely for individuals who do not qualify for employment-based health insurance. For example, under proposals made by House Majority Leader Dick

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[13] This advantage was substantially reduced when the tax rate structure was condensed by the Tax Reform Act of 1986 (TRA '86). It has been slightly increased since the passage of the Omnibus Budget Reconciliation Act of 1993.

[14] It can also be argued that the uninsured would be much higher if workers were not allowed to exclude any portion of health benefits from income, or if employers were not able to deduct health benefit expenses as a business expense.

[15] Unlike deductions or exemptions, which reduce the amount of income subject to a tax, a credit reduces the actual amount of tax owed, dollar-for-dollar.

[16] An individual with low income would have a very low tax bill, if he or she has one at all. An individual who does not pay taxes would be able to take advantage of the tax credit only if it is refundable. Refundable tax credits are needed when the objective is to allow individuals who do not pay taxes because they are in low-income families to benefit from the tax credit.

Table 1.2
Summary of Tax Change Proposals

Sponsor	Description	Status
Rep. Dick Armey (R-TX)	Would provide a refundable tax credit of $800 per adult, $400 per child, up to a family maximum of $2,400. Unused federal funds earmarked for the tax credit would go to the states as block grants to provide coverage to the uninsured. The National Committee for Policy Research and the National Association of Health Underwriters have virtually identical proposals.	Not yet introduced.
Rep. Jim McDermott (D-WA) and Rep. James Rogan (R-CA) [H.R. 1819]	Would provide a 30 percent tax credit to individuals earning less than $30,000 and joint filers with income of less than $50,000 for the purchase of health insurance. Eligible individuals could not be covered by an employment-based health plan.	Referred to House Ways and Means Committee.
Rep. Nancy Johnson (R-CT) [H.R. 2020]; Sens. Charles Grassley (R-IA) and Diane Feinstein (D-CA) [S. 1160]	Would provide a 60 percent tax credit to individuals earning less than $30,000 and joint filers with income of less than $50,000 for the purchase of health insurance. Maximum credit is $1,200 per individual and $2,400 per family. The credit would be phased out for individuals with incomes between $30,000 and $40,000 and families with income between $50,000 and $70,000. The credit would apply only to previously uninsured individuals and those with COBRA[a] coverage.	Referred to the Ways and Means Committee and the Senate Finance Committee.
Rep. Charlie Norwood (R-GA) [H.R.1136]	Would create a refundable tax credit for the purchase of individual coverage, with a lower credit available for out-of-pocket payments for employment-based coverage. Adults would qualify for a $1,200 credit and children a $600 credit, up to a maximum of $3,600 per policy. For those covered under an employment-based plan, the credits would be $400 and $200, respectively. The bill would also create "Health Marts" and association health plans. It would also repeal the limits on the number of medical savings accounts and the types of employers that could offer them.	Referred to the House Commerce, Education and the Workforce, and Ways and Means committees.
Rep. John Shadegg (R-AZ) [H.R.1687]	Would provide a $500 refundable tax credit to individuals and $1,000 for families to be used to purchase health insurance. Would allow those currently covered by an employment-based plan to opt out and purchase insurance on their own. Would also establish a risk pooling arrangement, possibly styled as "Health Marts." Would expand eligibility for medical savings accounts (MSAs) (no details available).	Referred to the House Commerce, Education and the Workforce, and Ways and Means committees.
Sen. Barbara Boxer (D-CA) [S.194]	Would allow the first $2,000 of health insurance costs to be fully deductible, for both itemizers and nonitemizers.	Referred to the Senate Finance Committee.
Sen. Ben Nighthorse Campbell (R-CO) [S.799]	Would allow an individual to deduct amounts paid for medical insurance or long-term care insurance, including amounts paid for a spouse and dependents.	Referred to the Senate Finance Committee.
Rep. Gene Green (D-TX) [H.R.145]	Would allow a deduction, for both itemizers and nonitemizers, for health insurance premiums (including Medicare). Also would allow a deduction for qualified long-term care insurance premiums.	Referred to the House Ways and Means Committee.
Sen. Richard Durbin (D-IL) [S.825]	Would allow small businesses (those with nine or fewer employees) a credit against income taxes when they provide employee health insurance coverage.	Referred to the Senate Finance Committee.

Source: Employee Benefit Research Institute.
[a]Consolidated Omnibus Budget Reconciliation Act of 1985.

Armey (R-TX) and Rep. Jim McDermott (D-WA), refundable tax credits would be available only to individuals who are not eligible for an employment-based health plan. Specifically, Armey has floated a proposal that would provide an $800 credit per individual and a $400 credit per child, up to an annual maximum of $2,400 per family, for those without access to an employment-based plan. McDermott is planning to reintroduce a measure he originally offered several years ago that would provide a partially refundable tax credit worth up to 30 percent of the cost of a health plan for low-income individuals. These proposals are intended to leave the employment-based health insurance system intact, as they are targeted to individuals who are less likely to be covered by an employment-based health plan or ineligible for one.

However, the movement to individual-based tax credits for any source of health insurance coverage may mean the end of the existing employment-based health insurance system. This has potentially enormous public policy implications, since the vast majority of Americans get their health insurance coverage through employers. Such a change may also have political implications, as public opinion currently may not support such a fundamental change in the U.S. health insurance system, as discussed later.

Different proposals for adding a tax credit would likely have different outcomes. For example, some proposals intend to preserve the employment-based health insurance system, while others intend to replace it.[17] Hence, a number of issues need to be considered in any debate over changing the tax treatment of health insurance coverage. Some of these issues are discussed below.

Rep. Thomas has argued that health insurance should be completely de-linked from employment and advocates changing the tax code to move away from the employment-based system. In general, Thomas argues that the major role played by employers in health insurance fundamentally distorts the economics of the health care market place. Specifically, he would completely replace the current health insurance-related tax code with an individual tax credit. Employers would not be able to deduct the cost of workers' health insurance as a business expense; instead, they would be expected to give workers a cash payment to obtain health insurance on their own. Thomas and Rep. Jim McCrery (R-LA), who have been developing the concept over the past few years, envision a private system of universal access to health insurance; as of this writing they have not introduced specific legislation.

But the assumption that employers would continue to provide the same contribution to their workers' health plan is questionable. Employers might choose to eliminate their contribution to health benefits and instead pay workers a higher (taxable) wage. Also, limiting the employer deduction would directly affect only those employers that pay federal income tax; it would not, for instance affect state and local governments or nonprofit institutions. However, these organizations would be indirectly affected, as they would be competing for the same pool of workers in the labor market, and it is likely that these employers would follow the behavior of employers that are subject to federal income tax.[18]

Proposals by Reps. Armey and McDermott would have less of an effect on the employment-based system than Thomas' proposal, although the Armey and McDermott bills could have different effects. First, under the Armey plan, only persons not eligible for employment-based coverage would be able to take the tax credit, although some employers might use this as an incentive to terminate health benefits. However, as long as workers continue to demand health benefits and unemployment continues to remain low due to a growing economy, and employers have to compete for scarce labor resources, employers may be reluctant to reduce health benefits. In an economic recession it would be relatively easy for employers to terminate health benefits, especially if workers could get a tax credit when purchasing health insurance on their own.

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[17] A number of members of Congress have introduced, or plan to introduce, additional proposals. Also, a number of associations have put forth similar tax credits proposals. They include the American College of Physicians - American Society of Internal Medicine (ACP-ASIM), the American Medical Association (AMA), the Blue Cross Blue Shield Association, and the National Association of Health Underwriters.

[18] The federal government introduced the Federal Employees Health Benefits Program (FEHBP) in 1959 in order to compete with private-sector employers for workers.

The McDermott proposal would have a much smaller effect on the employment-based system because the bill is targeted at low-income individuals. Only single persons earning less than $25,000 and married persons earning less than $40,000 would qualify for the tax credit under his bill. Since low-income individuals are least likely to have employment-based health insurance to begin with, the proposal would not be expected to have much impact on employment-based health plans. Under this proposal, persons eligible for the tax credit would be able to claim 30 percent of the cost of health insurance.

Rep. Charlie Norwood (R-GA) has introduced a bill that is similar in nature to Armey's proposal. The tax credit under Norwood's bill would be available to persons with employment-based coverage, but the amount that could be claimed under the tax credit would be much smaller for individuals who are eligible for an employment-based health plan. For example, individuals not eligible for an employment-based health plan could take an annual tax credit of up to $1,200, while eligible individuals could only take a $400 credit. While the tax credit is targeted toward individuals who are not eligible for an employment-based health plan, employers could still terminate a plan because individuals could then claim the tax credit if they purchased health insurance on their own, as in the Armey proposal.

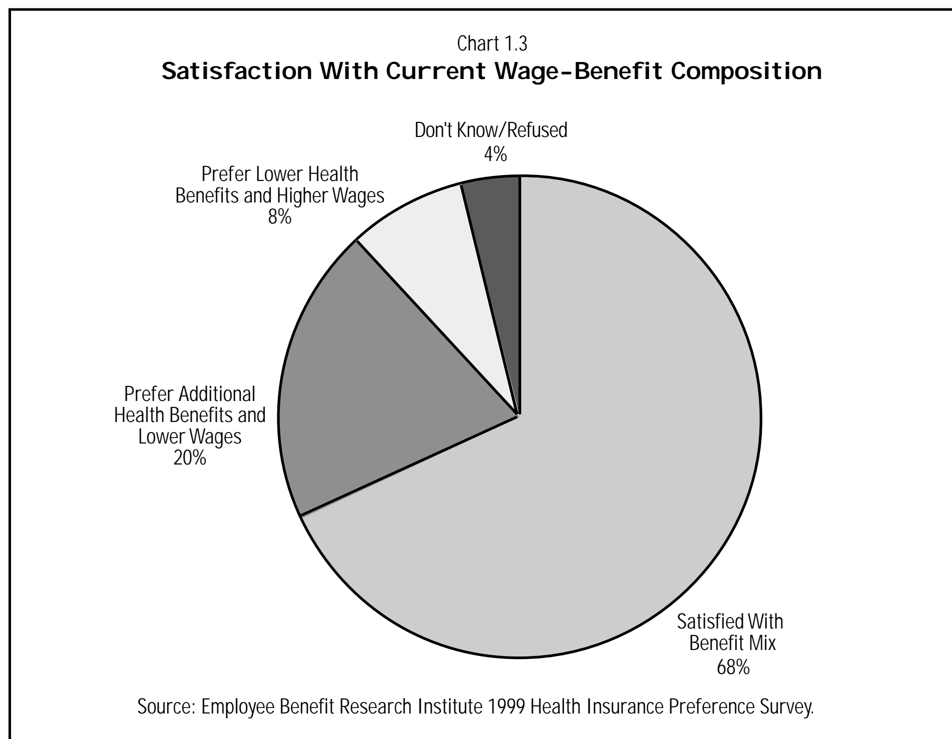
Additional Market Reforms

Proposals to change the tax treatment of health insurance in the past were generally combined with insurance market reform. These reforms usually included some type of "community rating," whereby all individuals who wished to enroll in a health plan were charged the same premium regardless of employment, family or health status. In essence, the goal of past proposals was to limit insurers' ability to charge different premiums to groups on the basis of risk, thereby allowing less healthy individuals to buy insurance at the premium that reflects the community's average risk. Some, but not all, current proposals include provisions that would allow smaller entities to band together to purchase health insurance at favorable rates, but in general they allow the market to determine premiums.

Another issue to consider is how employers would distribute funds if they were to eliminate health benefits in favor of higher wages. Health insurance is generally more costly for older individuals than for younger ones, since older people tend to have more health problems. This was reflected in a recent advertisement in a local Washington, DC, newspaper, which showed premiums for a 30-year-old ranging from $71 to $86 per month, while premiums for a 60-year-old ranged from $225 to $254 per month. If individuals are charged different premiums because of their age in the nongroup market, employers would face a number of issues in deciding how much money to give workers to buy insurance on their own. For example, would a 25-year-old worker get the same pay raise as a 50-year-old worker, or would the 50-year-old receive a higher pay raise because of the higher expected premium when premiums are not determined by average community risk? With an average premium in the above advertisement being $163, 60-year-old workers would not receive enough money to purchase health insurance on their own if the distribution were based on a community rate. This might result in older workers becoming underinsured and younger workers overinsured.

How employers ultimately distribute the funds would partly depend on how flexible employers could be under any final legislation. For example, employers might be required to "community rate" the distribution, i.e., to divide the distribution equally among all workers. All workers would get the same distribution regardless of age, although single workers might get a lower distribution than married workers if the plan subsidized family coverage.

If all workers received an equal distribution level, it is likely that older workers would not be able to purchase health insurance on their own solely with the funds distributed from their employer. Under the assumption that insurance carriers operating in the individual market are allowed to age-rate the premium, unhealthy individuals would likely pay higher premiums than healthy ones. If insurers set premiums using experience rating, there might be added pressure on employers to "cash-out" the benefit plan based on an actuarial (age-based) formula instead of a community-rated basis.



A question also arises concerning how the tax credit would be distributed. Current proposals set the credit either on a per-person basis or as a fixed percentage of the premium, and some proposals limit eligibility for the credit to individuals in low-income families. It is also possible to vary the tax credit by health status and/or age. The need to vary the tax credit by age and health status, and the subsequent effects of varying the tax credit, are highly dependent on whether premiums are community-rated or experience-rated.[19] If Congress continues to allow health insurance premiums to be experienced-rated, older and unhealthy individuals will likely pay more for insurance than younger healthy individuals. Under an experience-rated system, policymakers would ultimately have to decide whether to vary the tax credit by age and health status to address the issue of affordability.

■ Public Reaction

The success or failure of proposals to change the tax treatment of health insurance ultimately depends on the public's reaction. Since any change in the tax preference for health benefits may affect the real price of health insurance, it is important to understand how the public currently feels about employment-based health insurance, alternatives to the employment-based system, and changes to the tax code. For example, a recent public opinion survey conducted by the Employee Benefit Research Institute found that 68 percent of Americans with employment-based health insurance were satisfied with the current mix of benefits and wages (chart 1.3).[20] Twenty percent of respondents reported that they preferred *higher* health benefits and *lower* wages, while 8 percent reported the opposite preference—for lower health benefits

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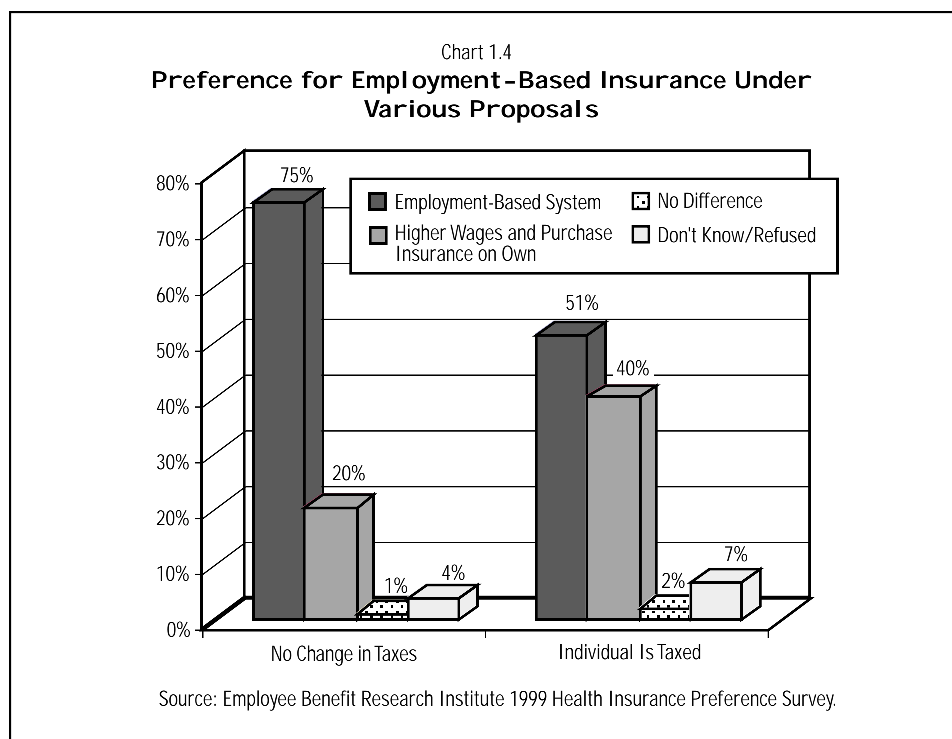
[19] *The value of the tax credit is also affected by geographic region, as health care costs and health insurance premiums vary by geographic region. Policymakers will also need to determine whether the value of the tax credit should be higher in high-cost regions, though they could simply set it at a fixed percentage of the health insurance premium.*

[20] *This survey was designed by the Employee Benefit Research Institute and Mathew Greenwald & Associates, and conducted by telephone in February and March 1999. Individuals ages 20 and older with employment-based health insurance were interviewed, with a sample size of 1,004. The margin of error for questions asked of all 1,004 is approximately +/– 3 percent.*



and higher wages.

The survey asked two questions in order to gauge who might opt out of the employment-based system. The first question asked about a proposal that would simply de-link health insurance from employment by giving workers higher income that could be used to purchase health insurance on their own. The second question was geared toward determining whether individuals would opt out of the employment-based system if health insurance benefits were subject to taxes. Under both questions, respondents were asked whether they would prefer that workers continue to get health insurance through employers or receive higher wages and purchase insurance on their own. Under the scenario in which the tax code is unchanged, 75 percent of respondents prefer that workers get health insurance through an employer (chart 1.4). Twenty percent would prefer a higher wage to purchase health insurance on their own, and 5 percent were indifferent, did not know, or refused to answer the question.

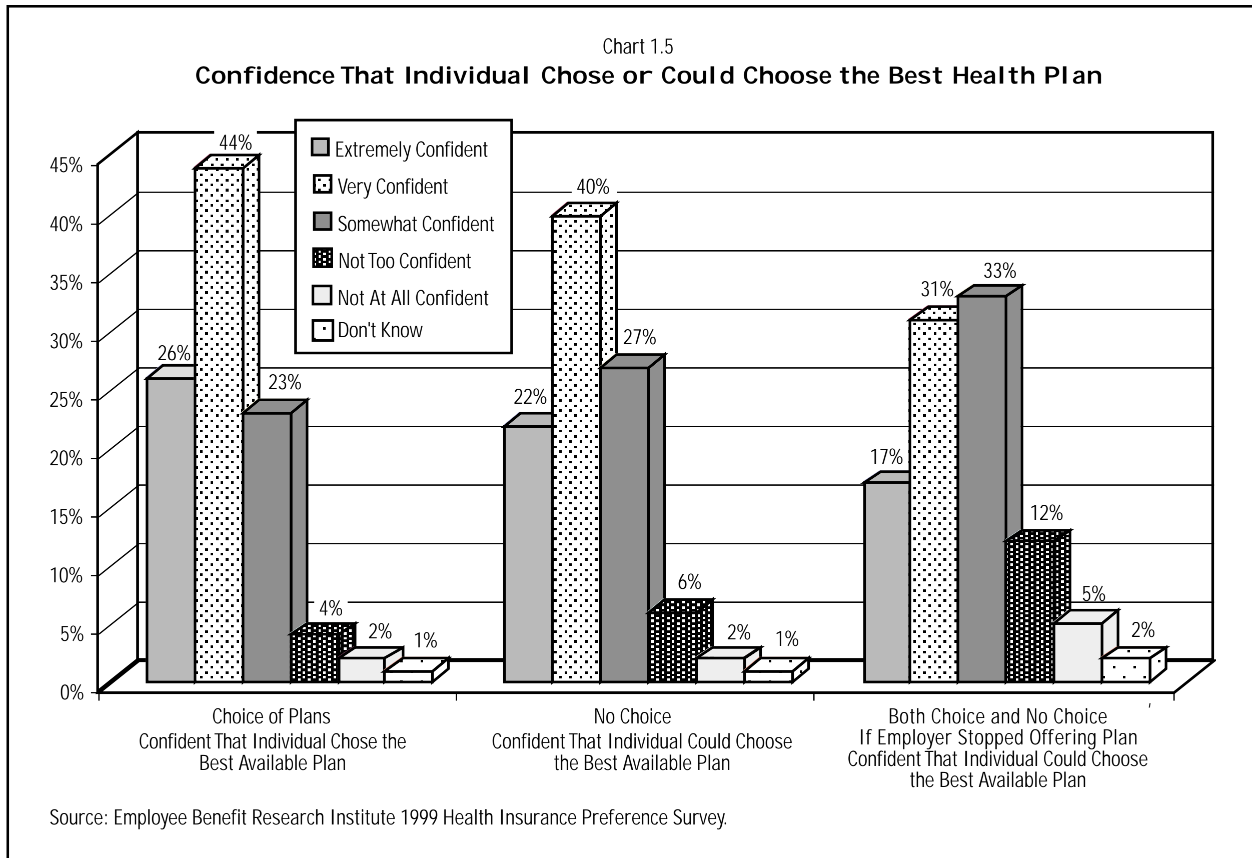
Under the changing tax code scenario, there is still strong support for the employment-based system, but support doubles for higher wages to purchase health insurance in the individual market, increasing from 20 percent to 40 percent (chart 1.4).

Strong support for the employment-based system may be the result of respondents' lack of confidence in their ability to choose the best health plan if their employer stopped offering health insurance. According to chart 1.5, 17 percent of respondents reported that they were not confident they would be able to choose the best health plan if their employer stopped offering health insurance. This compares with 6 percent who were not confident that they *did* choose the best health plan from the choices that their employer gave them and 8 percent not confident that they *could* choose the best health plan if their employer gave them a choice of plans.

Who Would Opt Out of Employment-Based Insurance?

The two questions used above to determine public attitudes toward employment-based health insurance and the alternatives through changes in the tax code were used to define three insurance personalities, as follows:

- Individuals with strong preference for the employment-based system.
- Individuals with strong preference for an individual-based system.
- Individuals with weak preference for the employment-based system.

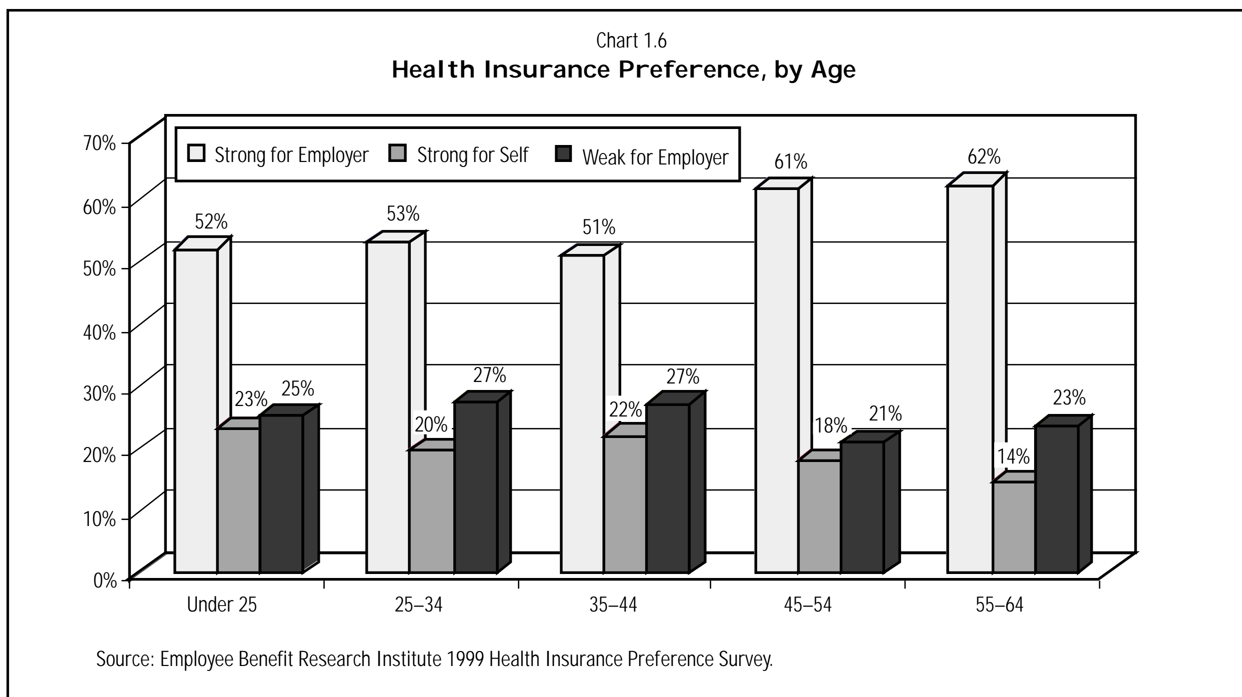


Individuals categorized as having a strong preference for the employment-based system reported that they favored workers getting their health insurance through employers whether or not the tax code was changed. Individuals categorized as having a strong preference for an individual-based system also reported that they favored it in both questions. Individuals categorized as having a weak preference for the employment-based system reported that workers should get health insurance through employers if the tax code was not changed, and reported that workers should receive higher wages to purchase health insurance if the tax exclusion for health benefits was removed. Overall, approximately 85 percent of the sample fit into one of these three categories.

The insurance personalities defined above were used to determine the characteristics of individuals most likely to be associated with the odds of opting out of employment-based coverage. It is important to understand who would and would not opt out of an employment-based health plan when given the choice, as the composition of those in and out of the system would affect the average premiums paid by these two groups, and ultimately, the sustainability of these two market systems.

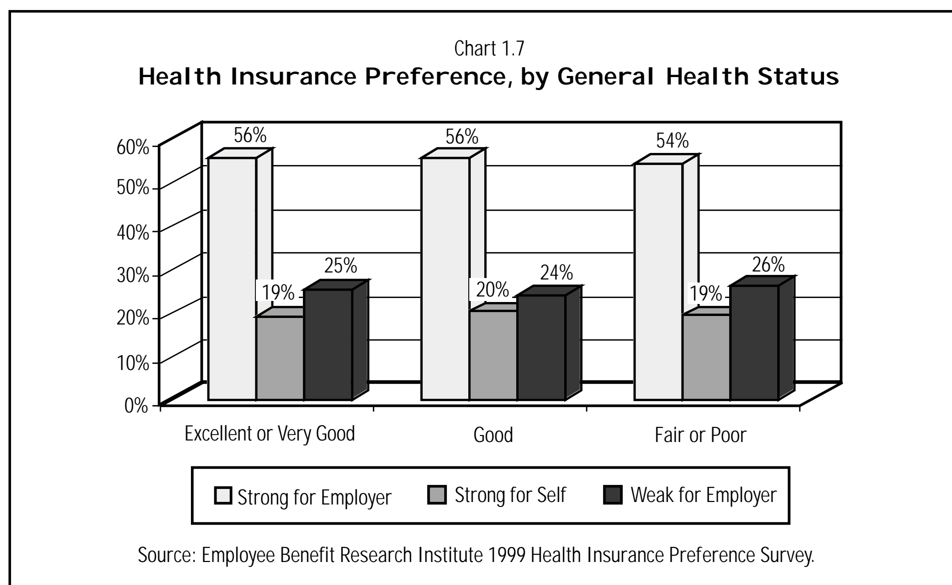
For example, if younger individuals are more likely to opt out than older individuals, or if healthy individuals are more likely than unhealthy individuals to opt out, average premiums would rise for individuals in the employment-based health insurance system, while average premiums would fall for individuals buying insurance on their own. It is also important to understand the characteristics of those likely to remain in an employment-based health plan, as this may indicate whether an employer would decide to continue or terminate a plan. This section summarizes the findings on the characteristics most likely associated with a person's decision to opt out of employment-based health insurance.

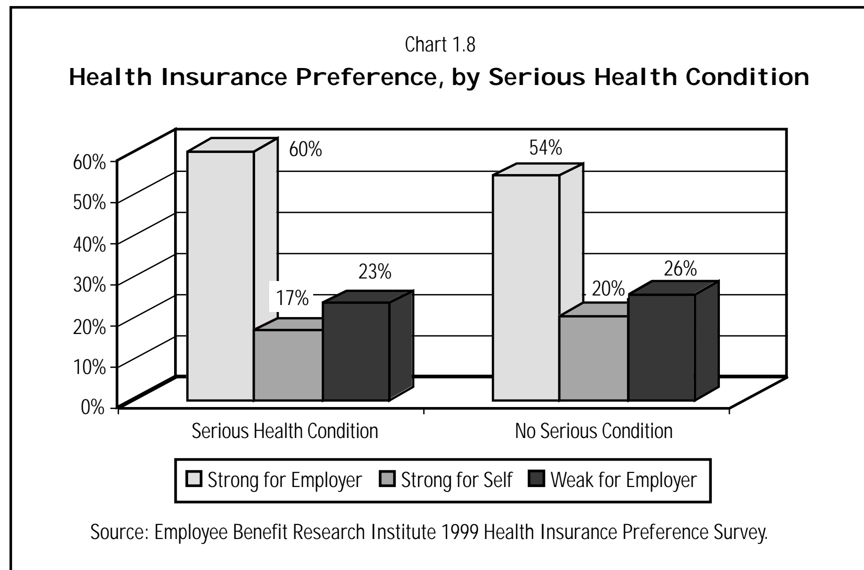
Gender and Age—The survey showed that men are more likely than women to have a strong preference for an individual-based health insurance system. Specifically, 22 percent of males are categorized as having a strong preference for higher wages to buy

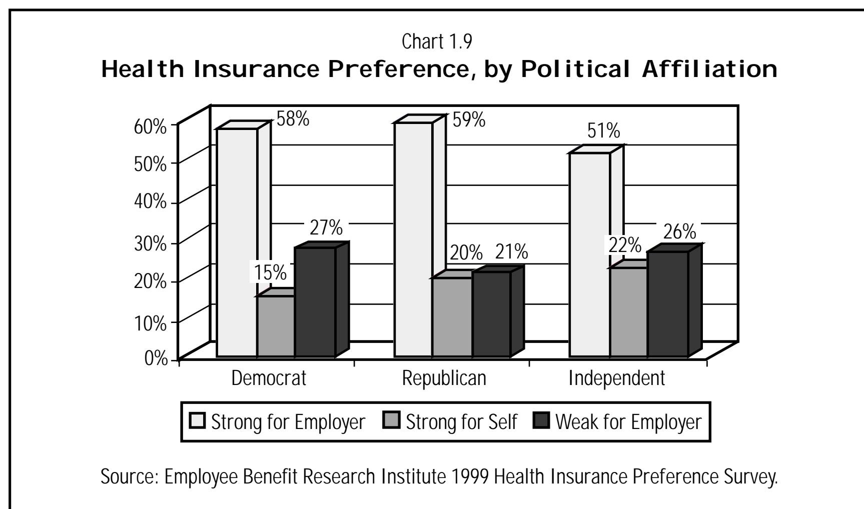


health insurance on their own, compared with 17 percent of women. It was also found that older persons are more likely than younger persons to strongly support the employment-based system and less likely to support an individual-based system, as shown in chart 1.6. The difference in support for an individual-based system is larger between the 55–64 age group and the under-45 group than it is for the 45–54 age group and the group under age 45. Since younger individuals are less costly than older individuals to insure, and males are less costly than females under age 45, if opting out of employment-based system became an option, the insurance risk pool would become more segmented, driving up premiums in the employment-based system and driving down premiums in the individual-based system.

Health Status—While the survey did not find any difference in system preference by general health status (chart 1.7), it did find weak evidence that individuals with a serious health condition are







more likely than those who do not have a serious health condition to support the employment-based system (chart 1.8). This suggests that individuals with a serious health condition may be uncertain about getting insurance on their own because of their health status. The findings do not suggest that individuals with health problems would be more likely to opt out of the employment-based system because of their dissatisfaction with managed care.[21]

Other Findings—The survey findings also show the following:

- Republicans are more likely than Democrats to support an individual-based system (chart 1.9).
- Persons dissatisfied with their health plan are more likely than satisfied persons to opt out of the employment-based system (chart 1.10).
- Individuals least confident in their employers' ability to select a health plan or extremely confident in their own ability to select a health plan are more likely than other individuals to opt out of the employment-based health insurance system (chart 1.11 and chart 1.12).
- Individuals who think their health plan is easy to understand are more likely than individuals who think it is hard to understand to opt out of

[21] These findings are consistent with what we know about elections under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): Workers in unhealthy families are more likely than workers in healthy families to continue coverage under COBRA, as evidenced by the large difference in utilization and expenditures between COBRA beneficiaries and active worker enrollees (Fronstin, 1998a).

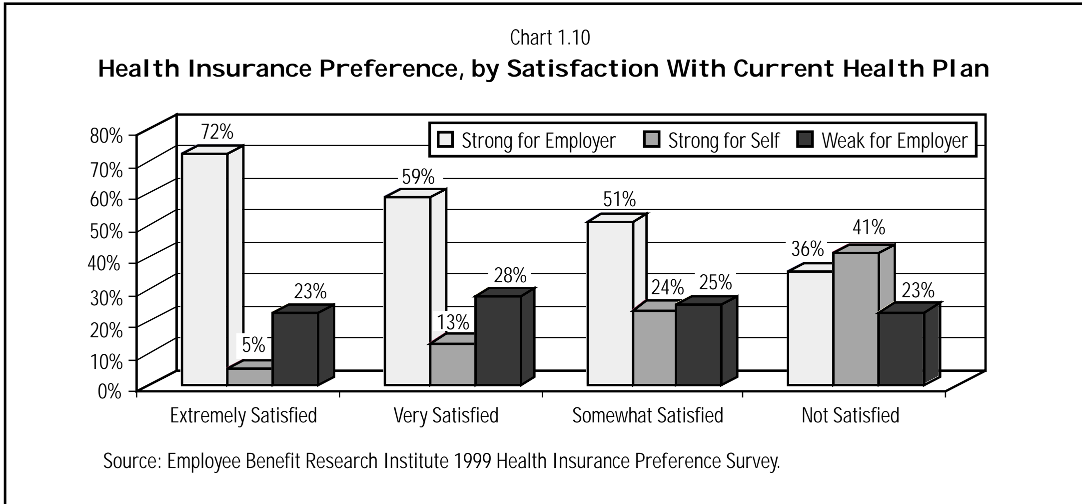


Chart 1.10

Health Insurance Preference, by Satisfaction With Current Health Plan

Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

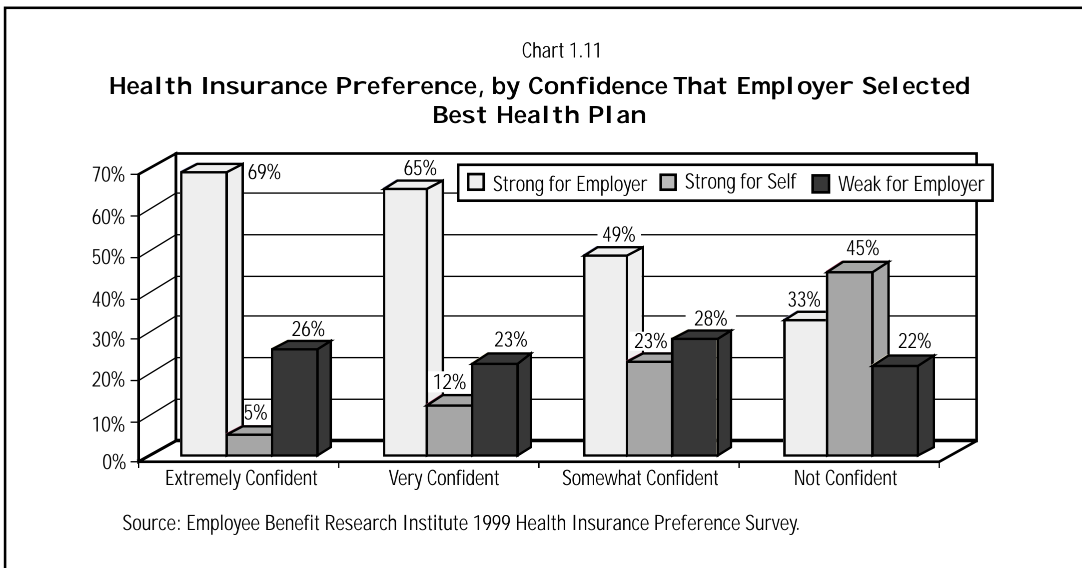


Chart 1.11

Health Insurance Preference, by Confidence That Employer Selected Best Health Plan

Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

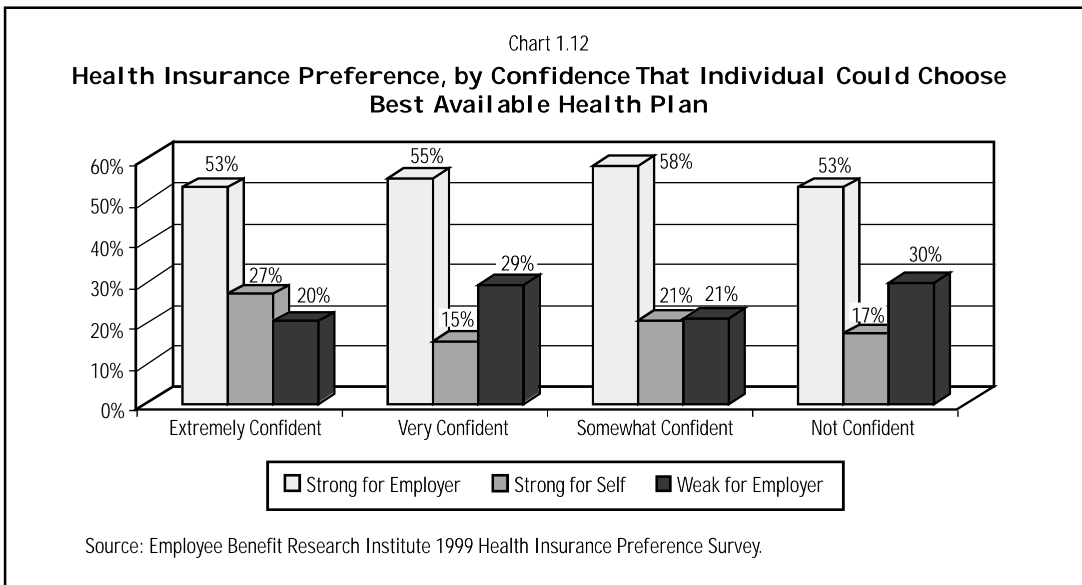


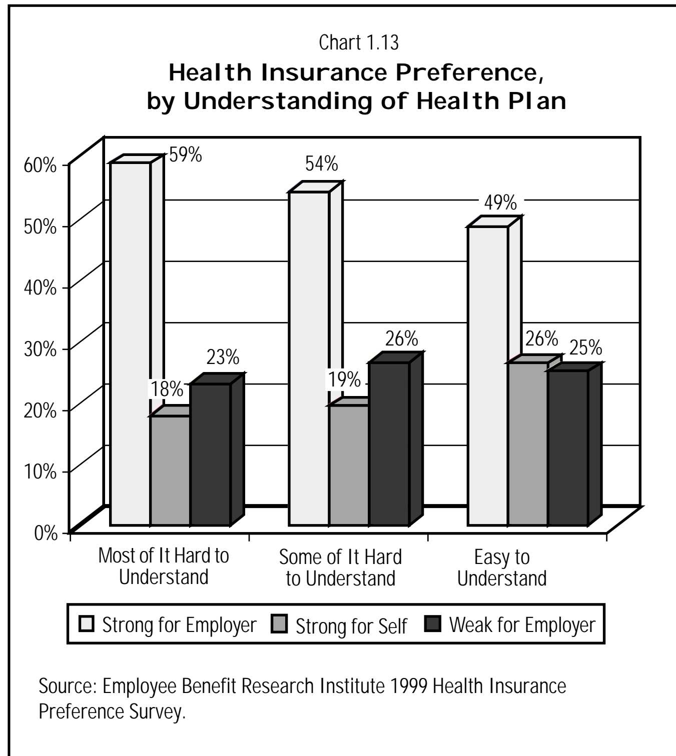
Chart 1.12

Health Insurance Preference, by Confidence That Individual Could Choose Best Available Health Plan

Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

the employment-based system (chart 1.13).

- There is evidence that individuals in health plans with a lot of managed care features (HMO-type plans) are more likely than individuals in fee-for-service plans to opt out of the employment-based system (chart 1.14).



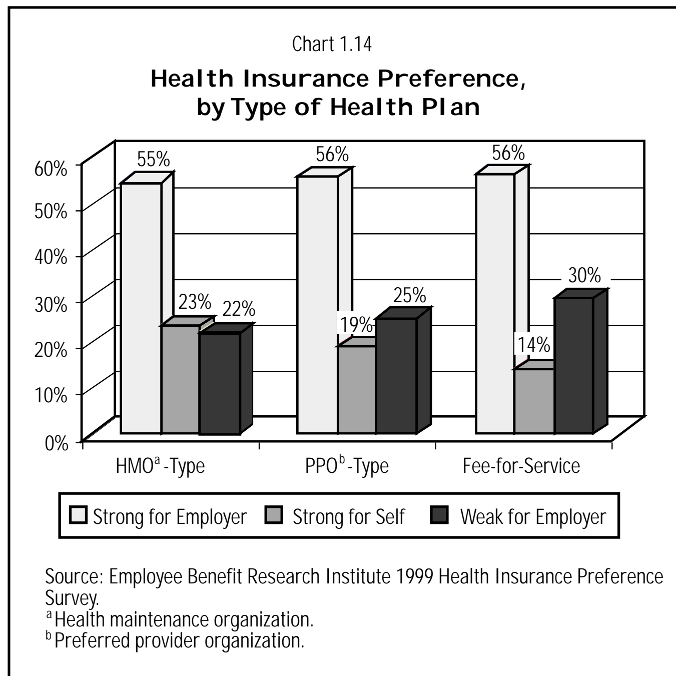
Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.

■ The Uninsured

While public opinion is always helpful in understanding support for various proposals and how individuals may respond, it is just as important to use existing data to determine the likely effects of changing the tax treatment of employment-based health insurance on coverage rates and the uninsured. This section summarizes recent studies that have examined various implications under a range of assumptions.

One of the concerns over changing the tax treatment of employment-based health insurance is that the change would erode (and potentially destroy) the employment-based system. As mentioned above, a tax credit may induce individuals to purchase health insurance on their own or it may make it harder for vulnerable populations to continue coverage. This has different implications for various segments of the insured and uninsured populations. For example, if only young healthy people choose to opt out of their employment-based plans, premiums would increase for individuals remaining in employer plans, while they would decline for individuals who opt out. This might have the unintended side effect of reducing coverage among individuals who remain in the employment-based system if the cost of employment-based health insurance is less affordable, ultimately increasing the uninsured population.

The current tax treatment of employment-based health insurance has been shown to be regressive in table 1.1, as discussed above. However, removing (or simply changing) the tax subsidy might not increase social welfare, as discussed in Custer (1999). The assertion that the tax treatment of employment-based health insurance distorts the market for health insurance, thereby creating an inefficient allocation of resources, is based on the assumption that the tax preference is the only reason the market for health care services is inefficient. If other factors prevent the health care system from performing optimally, the "theory of second best" suggests that changing the tax



Source: Employee Benefit Research Institute 1999 Health Insurance Preference Survey.
[a] Health maintenance organization.
[b] Preferred provider organization.

preference might not increase social welfare.

Custer (1999) found that removing the tax preference for employment-based health insurance would have a larger effect on individuals in families with at least one family member in fair or poor health than on families in which all members are in good health or better. Specifically, he found that if the tax preference for employment-based health insurance were eliminated, employment-based coverage would decline 17 percent for individuals in healthy families and 34 percent for individuals in unhealthy families.[22] Similarly, Monheit, Nichols, and Selden (1995/96) found that the employment-based system and its tax treatment act to transfer income from individuals in good health to those in poor health. Essentially, the tax treatment of employment-based health insurance acts to promote participation in health plans among low-risk individuals, which ultimately assists the pooling of risk.

Changing the tax treatment of employment-based health benefits might affect the overall level of the uninsured. Custer (1999), for example, found that removing the tax subsidy would reduce the number of individuals covered by an employment-based health plan by more than 20 million. While he finds that 3.5 million individuals would purchase coverage in the individual market, many others would not, resulting in a substantial net increase in the uninsured. Even if the tax treatment were changed so that anyone purchasing health insurance qualified for a tax credit, affordability would continue to be an issue for low-income workers.

Even repackaging the tax credit might affect the level of the uninsured. Thorpe (1999) found that introducing a tax credit would reduce the level of the uninsured, but the reduction would depend in large part on the level of the tax credit. Specifically, he found that an annual tax credit of $400 would result in 18 percent of single uninsured workers with incomes at 150 percent of poverty participating in a health plan. At a tax credit of $800, their participation would rise to 22 percent. As mentioned earlier, some proposals would set the tax credit at $500 for a single person. In order to achieve a take-up rate of 75 percent, Thorpe (1999) determined that the tax credit would need to be set at $2,800 a year for a single low-income uninsured worker.

While some members of the uninsured population would gain coverage under a tax credit system, others in the employment-based system might drop coverage, leading to a net change in the level of the uninsured that could be positive or negative. Attempting to model this net increase, Cox and Topoleski[23] (1999) found that the uninsured would increase between 0.2 million and 24 million people, depending on the generosity of the tax credit and the parameters used to determine eligibility for the tax credit.

Conclusion

Employment-based health plans are the most common source of health insurance in the United States, providing coverage to nearly two-thirds of the nonelderly population. Employment-based health benefits are also perceived by workers as the most important employee benefit. The question continues to arise as to whether the employment-based health insurance system is the most appropriate system for expanding health insurance coverage to the 43.1 million uninsured Americans in the United States.

While the employment-based health insurance system has numerous advantages over other types of financing and delivery methods, it also has many drawbacks. Job-lock and the differential tax treatment of health insurance by source of coverage are major concerns of policymakers and of many Americans.

The major complication involved in designing any system to expand coverage among uninsured individuals is how to avoid disrupting the current system that covers nearly two-thirds of the nonelderly population and inadvertently cause an increase among the uninsured in the United States.

Issues such as adverse selection, substitution of private insurance by public insurance, or

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[22] *Custer (1999) found that the percentage of individuals in healthy families with employment-based health insurance would decline from 70 percent to 58 percent. The percentage of individuals in unhealthy families with employment-based coverage would fall from 47 percent to 31 percent.*

[23] *See Donald F. Cox and Christopher Topoleski, "Individual Choice Initiatives: Analysis of a Hypothetical Model Act," in this issue.*

substitution of individual coverage for group coverage are inherent in the current voluntary employment-based health insurance system, and will not be resolved by incremental changes made to improve this system. For example, young and healthy individuals are more likely than older unhealthy individuals to opt out of the employment-based system under certain circumstances. As long as the purpose of insurance continues to be the spreading of risk across higher-risk and lower-risk individuals, attempts to augment or replace the employment-based health insurance system may have unintended side effects that do not benefit the majority of the U.S. population.

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2

The Tax Preference for Employment-Based Health Insurance Coverage

by William S. Custer

Introduction

Employment-based insurance is the foundation of the private health insurance system in the United States. In 1996, 91 percent of those Americans younger than age 65 with private health insurance obtained that coverage through employment-based plans, either directly as an employee or indirectly as a dependent of an employee. From the beginning of World War II until the early 1980s, both the number of people receiving employment-based health insurance coverage and the scope of that coverage expanded. This expansion, together with the introduction of the Medicare and Medicaid programs in 1965, greatly increased the number of Americans with health insurance.

One of the factors driving this increase in health insurance coverage was the tax treatment of health insurance as an employee benefit. Employer contributions for employee health insurance are excluded from income for the purpose of determining payroll taxes and federal and state income taxes. The effect of this exclusion is a subsidy for the purchase of health insurance for those individuals receiving coverage through the work place. This exclusion is the largest tax expenditure for the federal government. For FY 1999, the Office of Management and Budget estimated the federal income tax expenditure for the tax exclusion of employee health benefits to be $76.2 billion and $437 billion over fiscal years 1999–2003, excluding the expenditure for state income taxes, or federal payroll taxes. This tax exclusion has been standard accounting procedure since 1913, and was codified into law in Sec. 106 of the Internal Revenue Code (IRC), enacted in 1954.

Some economists have argued that the tax preference afforded employment-based health insurance provides an incentive for the purchase of too much insurance, which distorts the market for health services, yields an inefficient allocation of scare resources, and promotes health care cost inflation. (Feldstein, 1973; Feldstein and Friedman, 1977; Pauly, 1986). It has also been argued that the tax preference is a regressive subsidy in that it benefits higher-income individuals.

The assertion that the tax subsidy of employment-based health insurance coverage distorts the market for health insurance, and therefore creates an inefficient allocation of resources, is based on the assumption that the tax subsidy is the only reason the health care services market is inefficient. If there are other factors preventing the health care delivery and financing system from performing optimally, however, the "theory of second best" suggests that removing the tax subsidy may not increase social welfare.

There are two important reasons why the health care delivery system may not be allocating resources optimally in the absence of the tax subsidy for employment-based health insurance. One is that an individual's purchase of health care services has benefits to society at large. The other is that individuals have more information about their health status than insurers. Those with the greatest demand for health insurance are those with the greatest risk of needing care. As a result of this asymmetric information, insurers either have to go to the expense of acquiring information on the individual's health status (raising premiums) or increase premiums to account for the greater demand by those most likely to file a claim. In the extreme, the market for health insurance may not be sustainable.

This paper examines the effects of the tax subsidy for employment-based health insurance on

health insurance coverage. The variations in state income tax rates are used to estimate the relationship between that tax subsidy and coverage while controlling for factors that affect the individual's demand for health insurance, such as income, age, and self-reported health status. We find that the tax subsidy is most important for those whose income is between poverty and four times the poverty rate,[1] and for those whose self-assessed health status is fair or poor. These results suggest that the benefits of the tax subsidy accrue disproportionately to those with lower incomes and those in poor health who might otherwise remain without health insurance.

The Rationale for Subsidizing Employment-Based Health Coverage

One argument for some mechanism for subsidization of health insurance rests on the notion that there are positive benefits to society that arise from individual consumption of medical care.

- In the case of some preventive care and the treatment of communicable diseases, a direct positive externality arises from individuals obtaining treatment and thereby reducing the risk of transmitting disease to others. This particular benefit can be handled through the public health service and might not need to be considered in an essay on health insurance. However, evidence is that despite the presence of a public health department, most individuals obtain care related to communicable disease from their private health care provider.
- Often treatment and research go hand in hand, and technological advances depend upon individuals obtaining some treatments for which the marginal benefit to them may be small or negative.[2] For example, life expectancy among elderly heart attack victims increased 13 percent between 1984 and 1991 (Cutler et al., 1998). This enhanced life expectancy is as a result of refinements in treatment and outcomes research. Clearly the benefits of the care that supported the research will accrue to individuals not directly involved in financing it.
- Individuals who delay or do not obtain medical care impose a burden on society through decreased productivity in the work place.
- Society has shown an unwillingness to deny at least some level of care to individuals who need health care services but are unable to pay for that care. The distribution of the cost of that care may be much more inequitable than the distribution of the tax subsidy for employment-based health insurance.

The presence of these positive external benefits implies that without a subsidy, individuals would consume less medical care than society as a whole would find optimal. That the subsidy is provided through the work place is a consequence of the efficiency of the employment-based system in providing health insurance coverage.

The employment-based health system allows risks to be pooled more broadly than an individual insurance market can sustain. Individuals' choice of health insurance coverage in an individual market is determined by their self assessment of their own risks and their income. As a result, those with the greatest demand for health insurance are those most likely to use health care services. Premiums in the individual market are therefore higher to cover the costs of the greater risks.

Employer health plans are offered to employees and their dependents as a portion of a compensation package. Individuals' self assessment of their own risk is only one of a set of factors that lead them to accept or reject a job offer. As a result, more good risks remain in the employers' risk pools, reducing the effective premium and making employment-based health insurance more cost effective that the alternatives.

The exclusion of the value of the employer contributions for health benefits from an employee's income for tax purposes lowers the effective costs of health insurance for employees and increases health insurance coverage. Tying the exclusion expressly to employment-based plans

[1] *The poverty rate is determined by family size. For a family of four, poverty is a little more than $15,000 a year; four times poverty is about $63,000.*

[2] *The social benefits of research are continuously balanced with the individual costs of experimentation in medicine. Thus an individual may voluntarily participate in a research project knowing that he or she may not directly benefit from the treatment provided because of his or her altruism.*

provides an incentive for good risks to stay within the group, further increasing health insurance coverage.

An employer's decision to offer health insurance will depend upon the demand for health insurance by the work force the employer wants to attract and retain. Controlling for income, generally good risks will have a lower demand for health insurance than poorer risks. Increasing the tax preference for health insurance lowers the effective price of that coverage, inducing more good risks to demand employment-based coverage. Whatever decision rule the employer uses in choosing whether or not to offer coverage, the greater the demand for it by workers, the more likely employers are to offer coverage.

In summary, the lower the effective price of insurance, the more good risks will desire to purchase coverage. As the demand for insurance increases, more employers will elect to offer coverage. Once offered as a part of compensation, the vast majority of employees participate, reducing the effects of adverse selection. Thus the group purchase of health insurance through the workplace makes that coverage affordable to the most vulnerable members of society (the poorer risks).

■ Methods

Data for this study are from the March 1996, 1997 and 1998 supplement to the Census Bureau's Current Population Survey (CPS). For each observation in the sample, the marginal tax rate was calculated using a tax calculator based on the *ACIR Significant Features of Fiscal Federalism*, which was updated by researching the income tax code in each of the states. The appropriate source for each state tax code was obtained from the *National Survey of State Laws, 2nd Edition.* For more information on the tax calculation, see Custer and Ketsche (1999).

Private insurance coverage for each individual was classified as "direct" if obtained by an individual through his or her own employer, "indirect" if obtained as a dependent through an employment-based plan of another family member, and "other private" if obtained outside the employment-based market. The probability of having each of these three types of coverage was estimated separately as a logistic function of the known variables that determine coverage such as location, age, sex, education, marital status, number of dependents, occupation, industry, firm size, family income and self-assessed health status. We also included variables to control for the variation in state policy with respect to the small group and individual health insurance markets. The final sample of 232,850 observations represented approximately 162,250,000 adults, of whom about 76 million have coverage in their own name, 31 million have coverage as a dependent, and almost 11 million have other private insurance. (table 2.1). Based on the regression models, the probability of each of the three types of insurance coverage was estimated for the entire population. Results obtained were consistent with the actual insurance coverage status of the population. The model was then used to simulate the effect on insurance coverage status if the tax subsidy were eliminated by setting the marginal tax rate to zero.

■ The Effects of the Tax Subsidy for Health Insurance as an Employee Benefit

Insurance coverage changes with the individual's marginal tax rate, as is indicated in table 2.1. The percentage of adults in each marginal tax grouping with employment-based coverage rises as the marginal tax rate increases until the very highest tax rate. Those in the lowest tax bracket are the least likely to be insured through the private insurance market and the most likely to be uninsured. Interestingly, more than 80 percent of those in the highest tax rate have employment-based coverage and only 12 percent of them are uninsured, but these percentages represent less coverage than for those in the next lower tax rate.

The distribution of coverage by tax rate in table 2.1 reflects the progressiveness of the federal income tax system: Marginal tax rates increase as income increases. Our statistical analysis controls for factors that affect the demand for health insurance, such as income and health status, and the factors affecting the supply of coverage, such as firm size, industry, and regulatory environment. Perhaps the easiest way to understand the effect of the tax subsidy on health insurance coverage is to simulate the changes in coverage that would occur if the tax subsidy were removed.

Total Population

Approximately 66 percent of nonelderly adults (107 million) have employment-based health insurance coverage (table 2.2). The majority of adults with employment-based coverage have that coverage in their own name. Only about 7 percent of adults purchase private coverage outside the work place.

The impact of removing the subsidy would be significant. The number of adults with direct employment coverage would fall from 107 million to about 84.5 million. The percentage of adults with employment-based coverage through another's plan would fall from 19 percent to 11 percent. Some of those individuals would move out of the employment-based system into the individual market, increasing the percentage of adults with other private coverage from 7 percent to 9 percent.

These results indicate the magnitude of the incentive the tax treatment of health insurance as an employee benefit has on health insurance coverage. A little more than 20 million adults would no longer have employment-based health insurance in the absence of the tax subsidy. About 3.5 million more adults would purchase health insurance on the individual market. The ability to purchase coverage on the individual market would depend in large part on the individual's health status and income.

Health Status

Respondents are also asked to classify their current health status and the health status of every family member as excellent, very good, good, fair, or poor. Table 2.3 shows the source of coverage for adults by the self-assessed risk status of the individuals in their family. A little more than 27 million adult Americans (or about 17 percent of adults) live in families with at least one family member who rates his or her health as fair or poor. Those who describe at least one family member in fair or poor health are much less likely to have employment-based coverage and are more likely to be uninsured than those whose family members all rate their health as good or better.

Individuals in poor health would have less access to health insurance for a number of reasons. The most obvious is that insurers will avoid poor risks, if possible, to reduce adverse selection. Those in poor health are less likely to work, while those with family members in poor health may have employment opportunities limited due to their caretaker responsibilities. Thus health status may affect both access to health coverage and the

Table 2.1
Insurance Coverage by Marginal Tax Rate

	Total	Fica only	Up to 22.80%	22.8% to 28%	28% to 33%	33% to 37%	Over 37%
	Totals by Marginal Tax Rate — March CPS 1996, 1997, 1998						
Total	162,591,813	14,205,627	25,466,585	40,443,817	37,013,870	25,425,807	20,036,108
Employment-Based	107,634,792	2,147,704	12,751,359	26,754,013	28,662,894	21,091,928	16,226,895
Direct	76,318,236	1,589,998	9,720,584	19,467,641	20,358,271	13,807,093	11,374,648
Indirect	31,316,556	557,706	3,030,775	7,286,372	8,304,623	7,284,835	4,852,246
Other Private	10,634,547	1,280,283	2,095,239	2,832,482	2,109,120	1,271,719	1,045,704
Uninsured	31,207,630	5,354,539	7,427,806	8,378,118	5,019,326	2,619,565	2,408,276
	Percentage by Tax Rate Category						
Total	100%	100%	100%	100%	100%	100%	100%
Employment-Based	66	15	50	66	77	83	81
Direct	47	11	38	48	55	54	57
Indirect	19	4	12	18	22	29	24
Other Private	7	9	8	7	6	5	5
Uninsured	19	38	29	21	14	10	12

Source: Tabulations of the March 1996, 1997, and 1998 supplement to the Census Bureau's Current Population Survey.
Notes: Marginal Tax Rate (MTR) was calculated based on employee-paid payroll taxes and state and federal income taxes. The total for insurance categories may exceed 100 percent because individuals may have multiple sources of coverage.

Table 2.2
Insurance Coverage, Total Population, Actual and Simulated

	Actual Tabulations, Adult Population by Insurance Category		
	Total		Total
Total	162,591,813	Total	100%
Employment-Based	107,634,792	Employment-Based	66
Direct	76,318,236	Direct	47
Indirect	31,316,556	Indirect	19
Other Private	10,634,547	Other Private	7
Uninsured	31,207,630	Uninsured	19
	Simulation 1: Tax Subsidy=0		
Total	162,591,813	Total	100%
Employment-Based	87,491,474	Employment-Based	54
Direct	70,079,801	Direct	43
Indirect	17,411,672	Indirect	11
Other Private	14,131,799	Other Private	9

Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage*. Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

Table 2.3
Sources of Health Insurance for Adults by Self-Assessed Risk Status

	All Family Members Healthy	One or More With Health Fair or Poor	Total
Total	135,296,894	27,294,919	162,591,813
Employment-Based	94,847,829	12,786,963	107,634,792
Direct	67,525,735	8,792,500	76,318,235
Indirect	27,322,093	3,994,463	31,316,556
Other Private	9,109,228	1,525,319	10,634,547
Uninsured	24,504,431	6,703,200	31,207,631
	Percentages Within Risk Groups		
Total	100%	100%	100%
Employment-Based	70	47	66
Direct	50	32	47
Indirect	20	15	19
Other Private	7	6	7
Uninsured	18	25	19

Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage*. Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

Table 2.4
Health status by Income as a Percentage of Poverty

Income as a Percentage of Poverty	Percentage of Adults with Family Member in Fair or Poor Health
0–99%	33%
100%–199%	26
200%–399%	16
Over 400%	10

Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage*. Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

Table 2.5
Percentage of Adults With Employment-Based Coverage by Health Status

	0–99%	100%–199%	200%–399%	Over 400%
All Family Members Healthy	16%	46%	74%	86%
One or More With Fair or Poor Health	9	32	63	78

Source William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage.* Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

income needed to purchase it. Table 2.4 shows that those with low incomes are much more likely to rate their or a family member's health as fair or poor.

However, income is not the only factor in determining the health insurance coverage of the higher-risk groups. As table 2.5 indicates, those adults with at least one family member in fair or poor health are less likely to have employment-based health insurance coverage at every income level.

The magnitude of the effect of the tax subsidy on coverage varies considerably by health status. Absent the tax subsidy, the percentage of those adults with at least one family member in poor health with employment-based health insurance would fall from 47 percent to 31 percent: a drop of 16 percentage points. In contrast, the drop in the percentage of adults with healthy families would decline by 12 percentage points. Perhaps more telling, the percentage of the good risks with private coverage outside the employment-based system would increase by 3 percentage points, while the percentage of poor risks with other private coverage would fall slightly.

These results are consistent with a study by Monheit, Nichols and Selden (1995/96) in which the net distribution of benefits in the employment-related insurance market was analyzed using the 1987 National Medical Expenditure Survey. They found that the net benefits from health insurance were consistent with a transfer of wealth from

Table 2.6
Insurance Coverage by Self-Assessed Health Status of all Family Members

	Actual Totals, Adult Population			Percentages Within Risk Groups	
	All Family Members Healthy	One or More with Health Fair or Poor		All Family Members Healthy	One or More with Health Fair or Poor
Total	135,296,894	27,294,919	Total	100%	100%
Employment-Based	94,847,829	12,786,963	Employment-Based	70	47
Direct	67,525,735	8,792,500	Direct	50	32
Indirect	27,322,093	3,994,463	Indirect	20	15
Other Private	9,109,228	1,525,319	Other Private	7	6
Uninsured	24,504,431	6,703,200	Uninsured	18	25
	Simulation 1: Tax Subsidy=0			Simulation 1: Tax Subsidy=0	
Total	135,296,894	27,294,919	Total	100%	100%
Employment-Based	79,139,283	8,352,191	Employment-Based	58	31
Direct	63,351,474	6,728,327	Direct	47	25
Indirect	15,787,809	1,623,864	Indirect	12	6
Other Private	12,878,337	1,253,462	Other Private	10	5

Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage*. Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

Table 2.7
Insurance Coverage by Income as a Percentage of the Federal Poverty Level, Totals, Nonelderly Adults

	Income as a Percentage of Federal Poverty Level			
	0–99%	100%–199%	200%–399%	Over 400%
Total	18,339,688	26,411,386	53,135,651	64,459,615
Employment-Based	2,566,395	11,298,467	38,523,045	55,158,321
Direct	1,952,314	8,125,385	27,056,302	39,116,341
Indirect	614,082	3,173,083	11,466,743	16,041,981
Other Private	1,595,100	2,247,876	3,442,881	3,347,491
Uninsured	7,770,459	9,229,386	9,057,508	5,013,999
	Simulation: Tax Subsidy=0			
Total	18,339,688	26,411,386	53,135,651	64,459,615
Employment-Based	2,657,231	7,544,147	24,823,325	52,466,771
Direct	2,205,867	6,491,897	21,391,920	39,990,118
Indirect	451,364	1,052,249	3,431,406	12,476,653
Other Private	2,088,272	2,761,949	4,926,548	4,355,030
	Insurance Coverage by Income as Percentage of Federal Poverty Level Percentages Within Income Categories, Nonelderly Adults			
Total	100%	100%	100%	100%
Employment-Based	14	43	72	86%
Direct	11	31	51	61
Indirect	3	12	22	25
Other Private	9	9	6	5
Uninsured	42	35	17	8
	Simulation: Tax Subsidy=0			
Total	100%	100%	100%	100%
Employment-Based	14	29	47	81
Direct	12	25	40	62
Indirect	2	4	6	19
Other Private	11	10	9	7

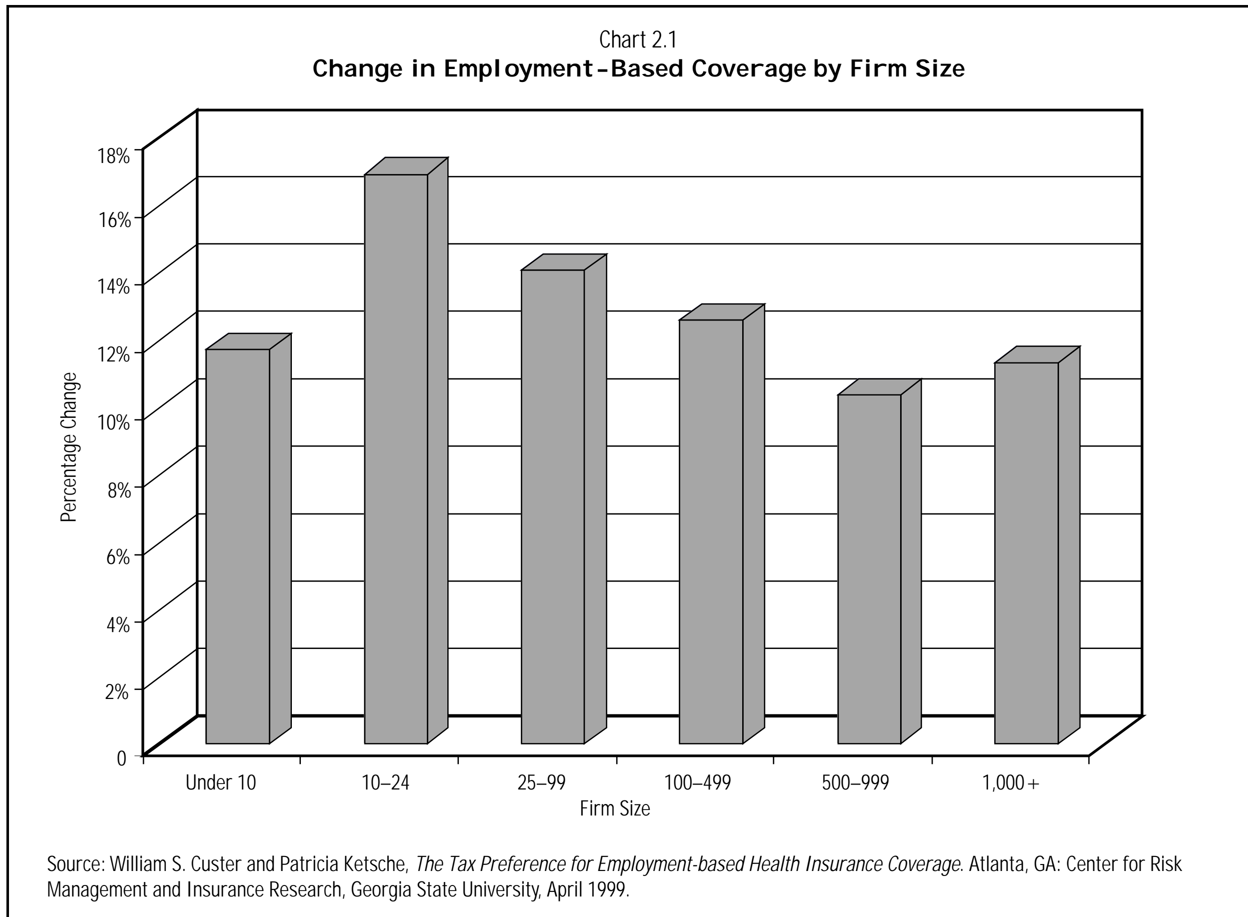
Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage.* Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

those in good health to those in poor health and that the tax subsidy of premiums promoted participation in health plans for those who would otherwise experience large net losses from participation. Their study provides some evidence that absent tax subsidies, low-risk individuals might leave pools at a higher rate than high-risk individuals because of the substantially negative net benefit from pooled insurance for the good risks.

■ Family Income

The effect of the tax subsidy varies significantly by family income. Those in the lowest and highest income categories are the least affected by the tax subsidy. It is those adults living in families with incomes between the federal poverty level and four times that level[3] who are most affected by the subsidy. Less than one-half of all adults live in families with incomes in that range, but almost 90 percent of the individuals who lose employment-based health insurance are in that income range. This suggests that while the benefits of the tax reduction may be regressive, in that high-income individuals are more likely to have coverage, the

[3] *The poverty rate is determined by family size. For a family of four poverty is a little over $15,000 a year, four times poverty is about $63,000.*



Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage*. Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

benefits of increased insurance coverage accrue to the lower-income workers and their families.

■ Employer Size

The effect of the subsidy on coverage by varies by employer size. Smaller employers may face higher costs for providing health benefits than larger employers provide for three reasons. First, their small size means that they are less able to spread risks. Second, their small size makes it harder for them to self-insure and avoid costly state mandates and taxes. Finally, they face higher administrative costs because they are less likely to have staff devoted to health benefits.

For the very smallest firms, those with fewer than 10 employees, the higher costs of health insurance may mitigate increased coverage due to the tax subsidy. The tax subsidy would have its greatest effect on coverage for employers on the margin. As chart 2.1 indicates, the impact of the subsidy is the greatest on firms with 10–24 employees. Its impact is significant, but it declines as firm size increases.

It is interesting to note the differences in the effect of the tax subsidy on the type of coverage by firm size. Employees of smaller firms are more likely to have coverage from someone else's plan than employees of large firms. Much of the reduction in coverage for employees of smaller firms affected by removal of the tax subsidy comes from decreases in indirect coverage.

■ Policy Implications

What this study has shown is that the consequence of the tax preference for employment-based health insurance coverage is significantly increased insurance coverage. The additional coverage induced by the tax preference is predominately among those of low to moderate income and those who are in poor health. This suggests that assessing the equity of the tax preference is more complex than just totaling the percentage of taxpayers with employment-based health insurance by income class.

More importantly, the effect of the tax

Table 2.8
Insurance Coverage by Firm Size, Nonelderly Adults

	Totals						
	Firm Size						
	Under 10	10 to 24	25 to 99	100 to 499	500 to 999	1,000 or More	Nonworkers
Total	26,198,409	12,302,559	17,061,499	18,343,195	7,753,892	51,078,976	29,853,285
Employment-Based	13,024,377	7,484,626	12,233,641	14,495,430	6,394,814	42,382,131	11,619,773
Direct	6,397,945	4,922,036	9,387,625	11,778,518	5,216,666	35,516,642	3,098,802
Indirect	6,626,432	2,562,588	2,846,015	2,716,913	1,178,149	6,865,487	8,520,972
Other Private	3,909,257	914,181	842,061	608,370	247,236	1,636,480	2,476,962
Uninsured	7,966,738	3,319,082	3,347,066	2,669,374	888,737	5,396,563	7,620,071
	Simulation 1: Tax Subsidy=0						
Total	26,198,409	12,302,559	17,061,499	18,343,195	7,753,892	51,078,976	29,853,285
Employment-Based	10,022,826	5,392,180	9,813,119	12,164,423	5,581,425	36,498,035	7,019,465
Direct	6,287,980	4,078,263	8,230,260	10,427,177	4,813,152	31,790,234	3,452,735
Indirect	3,734,847	1,313,917	1,582,860	1,737,246	768,273	4,707,801	3,566,730
Other Private	2,837,913	1,108,877	1,478,566	1,427,555	637,101	4,463,148	2,178,637
	Percentages with Firm Size Categories						
Total	100%	100%	100%	100%	100%	100%	100%
Employment-Based	50	61	72	79	82	83	39
Direct	24	40	55	64	67	70	10
Indirect	25	21	17	15	15	13	29
Other Private	15	7	5	3	3	3	8
Uninsured	30	27	20	15	11	11	26
	Simulation 1: Tax Subsidy=0						
Total	100	100	100	100	100	100	100
Employment-Based	38	44	58	66	72	71	24
Direct	24	33	48	57	62	62	12
Indirect	14	11	9	9	10	9	12
Other Private	11	9	9	8	8	9	7

Source: William S. Custer and Patricia Ketsche, *The Tax Preference for Employment-based Health Insurance Coverage.* Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, April 1999.

preference on coverage is simply an extension of the overall impact of the employment-based health care coverage system. Bundling the purchase of health insurance into total compensation reduces the effect of adverse selection on the insurance market. The employment system itself acts to extend coverage to moderate-income families and those in poor health who would not have access to health insurance in an individual market.

There is no alternative pooling mechanism to employment-based coverage in a *voluntary* financing system. The individual market cannot pool risks. Using associations or clubs as an alternative will fail because the value of health insurance will overwhelm the value of membership in almost every club or association, especially for the poorer insurance risks. As a result, pooling mechanisms through clubs or associations would face insurmountable issues of adverse selection.

Ironically, adverse selection is one of the issues facing the employment-based health care financing systems in the future. Health care cost inflation has increased the proportion of compensation devoted to health insurance. As health insurance becomes a more important component of compensation, labor market decisions by both the employee and employer become predicated on health assessments, reducing the benefits of the employment-based system. Changes in the tax treatment of the purchase of health insurance in

the individual market could also weaken the employment-based system by providing better risks and higher-income individuals with an incentive to move out of the employment system.

The alternative to the employment-based system can only be a mandatory health care system of some type. The majority of the developed countries have some sort of mandatory financing system for health care. It was a central feature of the Clinton health plan of 1994. Rising health care costs have led to an increase in the number of uninsured Americans and a decrease in the uninsureds' access to care. A decline in employment-based coverage of two million Americans in the early 1990s is in large part responsible for the political pressure to reform the health care delivery system.

In the last four years, the percentage of Americans with employment-based health insurance coverage has risen slightly as the economy has experienced a period of sustained growth. However, during this period the number of Americans without health insurance has continued to slowly grow.

The slowing of the rate of growth in the number of uninsured and the rebound in the percentage of Americans with employment-based coverage is explained by both economic growth and the moderation of health care cost inflation. However, many analysts are predicting that health care costs will increase at an accelerating rate over the next decade. If that happens, it is likely that the growth in the percentage of Americans without health insurance will also accelerate over that period. Increases in the number of uninsured may create a political dynamic that fundamentally changes the health care financing system.

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3

Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured

by Kenneth E. Thorpe

Introduction

Since the debate over comprehensive health care reform ended in 1994, the number of uninsured has risen by 9 percent. By 1997, more than 43 million Americans, approximately 18.2 percent of the nonelderly, were uninsured. Several approaches aimed at reducing the number of uninsured have recently been advanced. A common characteristic of these proposals is the use of the tax system; however, the populations targeted—and the approach taken in these proposals—differ significantly. Some reforms are truly incremental in nature, while others propose more comprehensive reforms.

This paper examines a broad range of the recent tax-based proposals for extending health insurance. In examining these approaches, the paper identifies the key design issues associated with using the tax system for covering the uninsured. This framework allows a comparison of how each of the incremental and more comprehensive proposals addresses these key issues. In addition to outlining a design framework, a major purpose of the paper is to discuss the impact of each proposal on reducing the number of uninsured. In addition, implications of the proposals for employers, and the future of employment-based health insurance, as well as impacts on the currently insured, will be examined.

Current Tax Treatment of Health Insurance

Several aspects of current tax treatment of health insurance have been targeted for reform, including:

- Tax treatment of employer-paid health insurance. Employer contributions to an accident or health plan are excluded from an employee's income.
- Tax treatment of health insurance for the self-employed. The self-employed may deduct a portion of the amount they pay for health insurance. During 1999, the self-employed may deduct 45 percent of this cost, while they will be able to deduct 100 percent of the cost by the year 2007.
- Cafeteria plans and flexible spending accounts. Employee contributions to so-called cafeteria plans (outlined under Sec. 125 of the Internal Revenue Code) may be made on a pretax basis. Such contributions allow participants to pay for health care expenses not reimbursed through another source and not claimed on the participant's income tax return with pretax income.
- Medical savings accounts (MSAs). Under certain circumstances, individual contributions to an MSA are deductible in determining adjusted gross income. Moreover, certain employer contributions can be excluded from gross income and wages for employment tax purposes.

Critics highlight at least three problems with the current tax treatment of health insurance. These problems include:

- Higher spending on health care. Subsidizing the price of insurance results in more insurance purchased—and higher spending on health care (although the higher rates of coverage are applauded in some quarters);
- Vertical and horizontal equity. Federal tax

subsidies depend on the nature of employment. In light of the different tax treatment of employment-based and individually purchased insurance, the price of health insurance for most wage and salary workers is lower than insurance for the self-employed. The tax treatment is also vertically inequitable as the value of the tax subsidy rises with income;
- Tax expenditures. The Joint Committee on Taxation recently estimated that the loss in federal income tax revenue associated with the tax laws highlighted above will exceed $334 billion between federal fiscal years 1999 through 2003.[1] If lost payroll tax revenue were included, the revenue losses would exceed $500 billion during this time period.

Tax Reform Proposals

Several changes in federal health tax law have recently been proposed. These proposals vary significantly, both in their goals and specific changes in tax law. The more comprehensive proposals would eliminate the favorable tax treatment provided to both the self-employed and those with employment-based insurance. The resulting tax increase would eliminate many of the problems highlighted above. The increase in federal revenues traced to the tax increase could be used to provide health insurance for the uninsured. In contrast to the current tax system, these proposals would direct the bulk of federal subsidies to low-income populations.

Other proposals also target the uninsured, but they either retain or actually expand the favorable tax treatment of insurance. These proposals differ, however, in the extent to which the favorable tax treatment of insurance is limited to employers. Some would expand this favorable tax treatment to other entities and purchasing groups (i.e., Health Marts). These proposals would likely erode substantially the number of people receiving insurance through an employment-based setting. One feature common to all proposals is the use of tax credits to reduce the price of insurance—and the number of uninsured; however, the designs of these proposals differ significantly in their effect on federal program costs, as well as the number of uninsured and insured plan participants.
The following sections examine some key demographics of the uninsured and subsequently examine several recent health tax proposals. The goals and key design features of these proposals are examined, with particular attention paid to their impact on program participation.

Key Demographics of the Uninsured

Most of the uninsured are in relatively low-income families. Nearly 70 percent of all uninsured adults live in "insurance" households at less than 200 percent of poverty (see table 3.1).[2] If states enrolled all children currently eligible for Medicaid, and extended their Title XXI (State-Children's Health Insurance Program, S-CHIP) program to all potentially eligible children, more than 9 million uninsured children could receive insurance. When combined with the children's programs, policies targeting adults under 200 percent of poverty could potentially extend insurance to more than 75 percent of the 43 million uninsured. Several proposals specifically target these low-income households, while others make credits available to all Americans.

As they target different groups, the tax-credit proposals discussed below will extend coverage to varying numbers of the uninsured. The following sections provide a brief examination of these proposals.

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[1] *Joint Committee on Taxation,* Estimates of Federal Tax Expenditures for Fiscal Years 1999–2003*. Prepared for the Committee on Ways and Means and Committee on Finance (U.S. Government Printing Office, Washington DC, Dec. 14, 1998). Tax expenditures are not estimates of changes in federal revenues associated with changes in tax law. Tax expenditures do not include revenue losses from payroll tax receipts. Moreover, tax expenditures do not measure increases in revenues associated with changes in tax law. For instance, revisions in tax law would elicit changes in behavior not measured in estimates of tax expenditure. Such changes would affect revenues.*

[2] *An insurance household is a collection of individuals that would be covered under a typical private insurance plan. It is a more narrow definition than the census "household" concept used typically to tabulate the distribution of insurance coverage by household income.*

Table 3.1
Distribution of Uninsured by Health Insurance Unit Income as A Percentage of Poverty, 1997 (Millions)

Income as Percentage of Poverty	Adults	Children	Medicaid Eligible	Children Who are Potentially S-CHIP Eligible	Total
0–100	12.4	5.8	4.7	1.1	18.2
101–200	9.2	3.2	6.7	2.5	12.4
201–300	4.6	1.3	0	0.1	5.9
301 +	5.6	1.3	0	0	6.9
Total	31.8	11.6	5.4	3.7	43.4

Source: Tabulation from March 1998 *Current Population Survey.*

Key Design Decisions Influencing the "Success" of the Tax Credit Approach

The ability of tax-credit proposals to reduce the number of uninsured will hinge on the resolution of several key design issues. These include:

- Dollar value of the tax credit. Program participation among the uninsured depends critically on the size of the tax credit. Smaller credits will result in lower participation. At issue is the sensitivity of consumers' decisions to participate in the program as the size of the tax credit varies. A broad body of empirical research illustrates that program participation is indeed highly sensitive to the out-of-pocket price of insurance facing individuals and families. [3]

Several aspects of the design of a tax-credit proposal will affect the out-of-pocket price of insurance. The first obviously concerns the dollar value of the tax credit. A second issue concerns the timing of when the credits are received. Typically, tax credits are generally available for eligible families when filing their tax returns. Thus, eligible families would have to purchase insurance during the year—and wait for a credit during tax filing season, an unlikely scenario for many low- and moderate-income families. Use of an advanced payment option, allowing those eligible to receive the credit in their paycheck, would address this timing mismatch. A key issue is whether eligible tax filers would select the advanced payment option. For instance, only about 1 percent of all those eligible generally select the advanced payment option available under the earned income credit (EIC).[4] A final issue is whether the tax credit is refundable. If so, taxpayers would receive the difference between their federal income tax liability and the credit as a direct payment.

Chart 3.1 illustrates the relationship between the percentage of eligible uninsured purchasing insurance and the size of the tax credit. For the illustration, we examine the percentage of single workers at or near 150 percent of poverty who would purchase insurance with different tax credits. The illustration also assumes that the cost of insurance is $2,800 per adult. Using the experience of other federal programs, only 75 percent to 80 percent are likely to participate even when insurance is free (i.e., those eligible for the program receive a tax credit to cover the full price of insurance). At the other extreme, approximately 16 percent of those eligible for the program would purchase insurance with a $200 tax credit, while 22 percent would purchase insurance with an $800 tax credit.[5] Indeed, a $2,400 tax credit would be required in this example to get more than half of the eligible uninsured at this income level to purchase health insurance.

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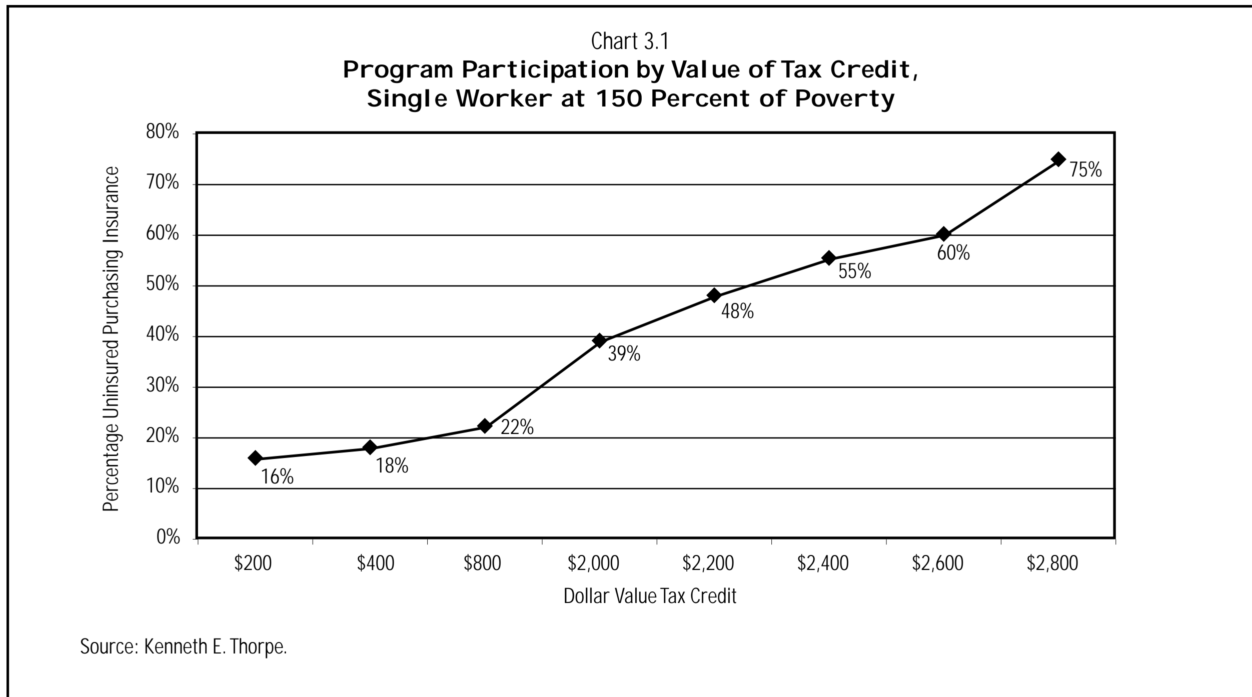
[3] *See, for example, S.M. Marquis and S. Long, "Worker Demand for Health Insurance in the Non-Group Market,"* Journal of Health Economics, *Vol. 14, no. 1 (1995): 47–63.*

[4] *Unpublished data, U.S. Treasury Department*

[5] *These participation rates are derived from the work of Marquis and Long, and Lewin-VHI,* Expanding Insurance Coverage without a Mandate, *a report for the National Leadership Council (Fairfax, VA, 1994).*



Source: Kenneth E. Thorpe.

- Who is eligible for the program? Some proposals limit participation to the currently uninsured, while other proposals allow those with insurance to participate. Broader definitions of program eligibility will, of course, result in higher federal costs per newly insured. On the other hand, such proposals may have broader and different goals than simply covering the uninsured.
- Who receives the tax credit? Individuals, employers, or others could be the recipients of a tax credit. Some proposals target individuals, and in some cases individuals in certain income thresholds. Other proposals may target small employers. Targeting individuals is the most direct route because it directs subsidies to those in need. In contrast, targeting smaller firms may direct federal subsidies to low- as well as high-wage workers. Although average wages are positively correlated with firm size, many smaller firms that do not offer insurance employ workers with relatively "high" wages. Most small firms (and large ones for that matter) employ a mix of low- and high-wage workers.[6] Moreover, targeting firms also creates incentives for larger firms to outsource workers, create smaller firms, and attract federal subsidies to purchase insurance.
- Who markets and administers the program? The Internal Revenue Service (IRS) is particularly well suited for administering the tax-credit component of any program—including advancing the credit in workers' weekly or monthly checks. Beyond this, other means of administering the program will be required, such as providing affordable insurance and determining eligibility for the tax credits during the year. Simply providing individuals with subsidies, and "throwing" them into the individual market to purchase insurance, is likely to generate several problems, including higher program costs. Thus some entity will have to serve as the broker or link between program participants and health plans.

One of the key implementation roles is marketing and advertising the program, which is an important determinant of program enrollment.[7] Indeed, previous programs that offered subsidized

[6] *National Center for Health Statistics, National Employer Health Insurance Survey (NEHIS) (Washington, DC: Department of Health and Human Services).*

[7] *K.E. Thorpe et al., "Reducing the Number of Uninsured By Subsidizing Employment-Based Health Insurance: Results from a Pilot Study,"* JAMA.*, Vol. 267, no. 7 (1992): 945–48.*

Table 3.2
Key Design Features of Some Tax Credit Proposals

	Incremental Reforms				Structural Reforms	Comprehensive Reforms
	Refundable tax credits, retains current tax treatment of employer-sponsored insurance (ESI)				Expands tax Exclusion beyond employer, plus refundable tax credit	Eliminates current employer-paid health insurance exclusion, plus refundable tax credits
Design Feature	ACP-ASIM[a]	BCBS[b]	H.R. 539 McDermott	H.R. 1136 Norwood	Congressman Shadegg	Congressman Thomas
Market Structure:						
Who Organizes and Offers Insurance?						
Existing ESI, individual	X	X	X			
ESI plus health marts plus individual				X	X	
Individuals and health marts						X
Target Population						
Low-income uninsured, those not ESI eligible	X		X			
Low-wage workers in small firms		X				
Those with ESI plus uninsured				X	X	
Entire Population						X
Sources of Funding						
Budget surplus	X					
Revenue from eliminating employer tax exclusion						X
Disproportionate share spending	X					
Unknown		X	X	X	X	

Source: Kenneth E. Thorpe.
[a]American College of Physicians – American Society of Internal Medicine.
[b]Blue Cross and Blue Shield Association.

health insurance to employers and workers were plagued by notoriously low participation rates. Lack of knowledge of the program was among the major culprits.

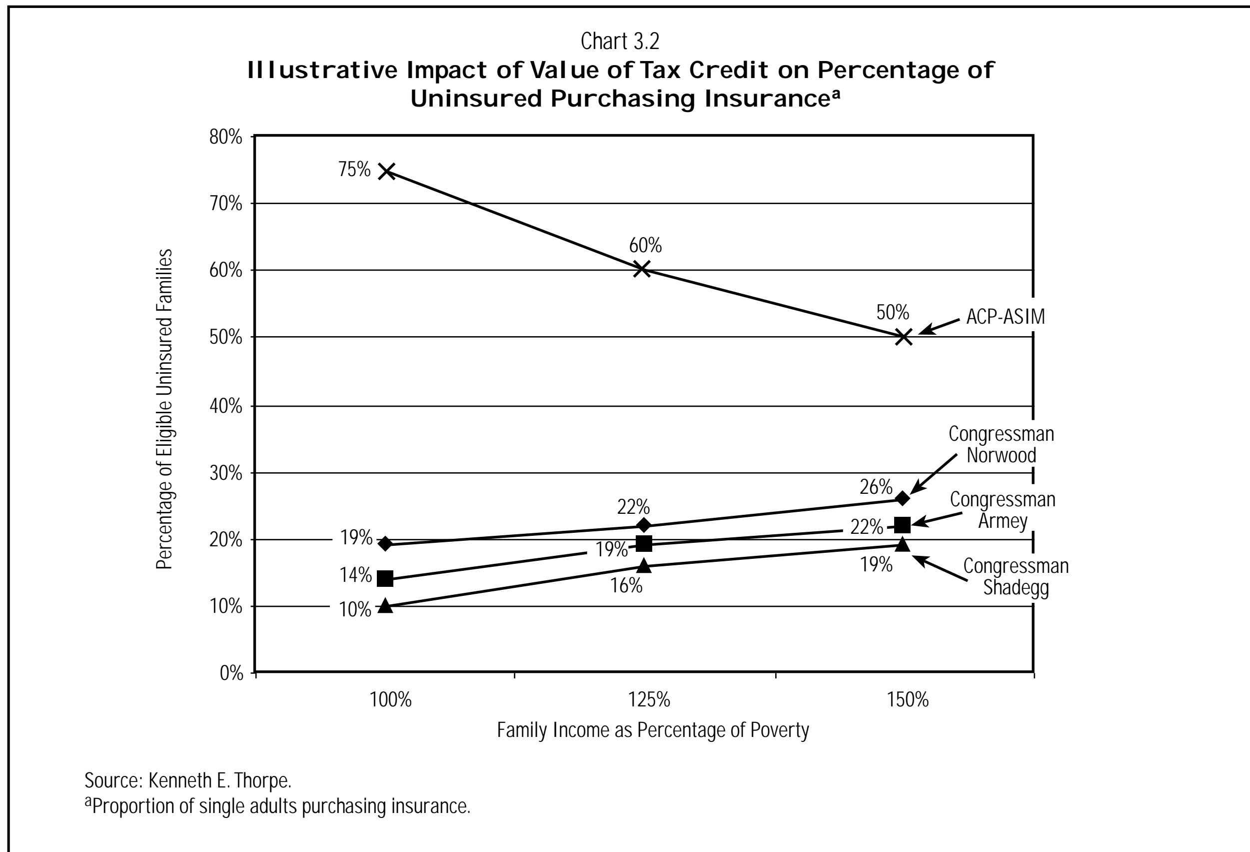
■ Proposed Changes to the Tax Treatment of Health Insurance

Several proposals have been advanced to alter the existing tax treatment of health insurance. These proposals generally fall into three groups, ranging from incremental reforms to more comprehensive and structural changes. All have a common element, the use of tax credits to subsidize the purchase of health insurance; however, they differ in several key dimensions as well. Table 3.2 presents a brief overview of some of these proposals.

The three approaches include:

- Use of refundable tax credits to reduce the price of insurance while retaining the current tax treatment of health insurance benefits (incremental reforms);
- Use of refundable tax credits but broadening the favorable tax treatment of insurance beyond the employer (structural reform);
- Use of refundable tax credits and elimination of the tax-favored treatment of employment-based benefits (comprehensive reform).

Although each proposal relies on tax credits, the proposals alternatively retain, expand, or eliminate the current tax-favored status of employment-based insurance. Moreover, the designs of the tax-credit portion of these proposals also vary in important dimensions. Table 3.2 highlights three key differences among these proposals. The first concerns who sponsors health insurance or whether the tax preference is extended to other entities—such as purchasing groups (designated as Health Marts below). A second key issue concerns the populations targeted.



The more limited proposals target the uninsured, while the more comprehensive proposals extend eligibility to all Americans. Finally, the approaches also differ in the sources of funding. These differences are elucidated below.

■ Incremental Tax Reform Proposals

By their nature, incremental reforms target a portion of the uninsured. The impact of such reforms will depend critically on several of the key design features highlighted above, including the population eligible as a percent of poverty, current insurance status, and the generosity of federal tax credit subsidies. The incremental reforms discussed below would largely—although not entirely—retain the current tax treatment of health benefits.[8] Instead, these reforms focus largely on directing federal tax subsidies to certain populations, ostensibly to increase coverage. The proposals differ in several key respects, however. These differences will affect the number of currently uninsured who would purchase insurance, the number of currently insured who would substitute coverage, the impact on employers, and the federal budgetary costs.

Two recent proposals, one advanced by the American College of Physicians, American Society of Internal Medicine (ACP-ASIM), and another by the Blue Cross and Blue Shield Association (BCBSSA) are excellent cases in point. A refundable tax credit (using an advanced payment option) is one of several elements of the proposal advanced by the ACP-ASIM. This proposal would provide a full tax credit of $2,800; as such, it would cover the full cost of health insurance for benefits similar to the Blue Cross and Blue Shield standard option plan in the Federal Employees Health Benefit Program (FEHB) to all uninsured at the federal poverty line. The value of the tax credit would be reduced

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[8] The Blue Cross and Blue Shield Association proposal would expand the tax deductibility of insurance in two ways. First, it would accelerate the date when the self-employed can fully deduct the cost of insurance. Second, it would extend full deductibility to those without employment-based health insurance.

Table 3.3
Distribution of Workers by Hourly Wage and Firm Size, 1997 (millions)

Hourly Wage	Firm Size: Under 10		10–24		25–99		100–499		500–999		1,000+		Total	
	number	percentage	number	percentage	number	percentage	number	percentage	number	percentage	number	percentage	number	percentage
Under $5	12.5	50.4%	2.2	9.0%	2.3	9.2%	1.9	7.5%	0.7	2.7%	5.3	21.3%	24.8	100%
$5.01–$10	7.8	17.9	5.1	11.7	6.5	15.1	6.1	14.0	2.4	5.4	15.6	35.9	43.4	100
$10.01–$15	4.0	12.7	2.8	9.0	4.5	14.3	4.8	15.4	2.1	6.6	13.2	42.0	31.3	100
$15.01+	4.9	10.8	3.1	7.0	5.1	11.3	6.3	14.0	3.0	6.7	22.7	50.3	45.1	100
Total	29.1	20.2	13.7	9.2	18.4	12.7	19.1	13.2	8.1	5.6	56.7	39.2	144.6	100

Source: March 1998 Current Population Survey.

(linearly) to $2,400 for uninsured adults at 150 percent of poverty.

Several aspects of the ACP-ASIM proposal would contribute to a relatively high number of eligible uninsured purchasing insurance. The first is the size of the credit, which is comprehensive for those at poverty. Even for those at 150 percent of poverty, the credit would still subsidize more than 85 percent of the cost of insurance.[9] Second, the proposal would piggyback on the current administrative structure developed by the states to implement Title XXI, the State-Children's Health Insurance Program (S-CHIP). This would allow the states to extend their existing administrative systems currently used to verify income and insurance status for low-income children to adults. Once enrolled in the program, those eligible could select an advanced payment option to secure the tax credit. Use of an advanced payment option would place the tax-credit dollars in the monthly or weekly paychecks of those enrolling in the program.

Given the size of the tax credit, approximately 75 percent of the currently uninsured living at or near the poverty line would likely purchase health insurance (see chart 3.2). However, even with the generosity of the ACP-ASIM tax-credit program, participation rates would fall to 60 percent of uninsured eligibles at 125 percent of poverty and approximately 40 percent at 150 percent of poverty.

Although similar in focus, the BCBSSA proposal would target tax credits to small firms for low-wage workers. Proposals that target firms and workers by their hourly wage will direct federal subsidies to different workers than those targeting individuals by household income. Federal costs will be higher per newly covered uninsured in proposals that target firms and low-wage workers relative to proposals targeting low-income uninsured individuals.

Targeting employers raises several issues that could reduce the "target efficiency" of a tax-credit program. The first issue concerns the mix of insured and uninsured, high- and low-wage workers within small firms. Although there is a strong relationship between average payroll and firm size, low-wage workers are not concentrated in small firms. For example, approximately 30 percent of very low-wage workers (those earning less than $5 per hour) work for firms with 100 or more workers (see table 3.3). Thus, many low-wage, uninsured workers would not be eligible for subsidies under a firm-based approach. In addition, the percentage of low-wage uninsured workers is remarkably similar across firms. Indeed, low-wage workers are approximately as likely to be uninsured in large, medium, or small firms (see table 3.4). For instance, 30 percent of very low-wage workers employed in firms with fewer than 10 workers were uninsured during 1997, compared with 26.6 percent in the very largest firms.

A second issue concerns the relationship between hourly wage and family income. Nearly 30 million families have dual workers. An analysis of working families indicates that low wage is not necessarily the same as low family income. For instance, nearly a third of all very low-wage earners (less than $5 per hour) live in families with

[9] Two adults purchasing insurance with these credits would pay approximately 3 percent of their income at 150 percent of poverty to purchase health insurance.

Table 3.4
Low-Wage Workers by Firm Size and Insurance Coverage, 1997 (millions)

Firm Size	Total Low-Wage Workers[a]	Number Uninsured	Percentage Uninsured
Under 10	12.5	3.7	30.0%
10–24	2.2	0.8	36.4
25–99	2.3	0.7	30.4
100–499	1.9	0.5	26.3
500–999	0.7	0.2	28.6
1,000 +	5.3	1.4	26.4
Total	24.8	7.2	29.0

Source: March 1998 *Current Population Survey.*
[a]Earning $5 per hour or less.

income higher than 200 percent of poverty, with more than 20 percent of such workers in families earning three times the poverty limit. Indeed, many low-wage workers are "secondary workers" and live in households with higher incomes (see table 3.5).

Targeting low-wage workers in small firms also creates incentives for outsourcing. For instance, large firms with low-wage workers could create separate firms of low-wage workers to attract federal tax credit subsidies. This clustering of low-wage workers into small firms would increase the federal costs associated with the proposal. It could be argued that insured, low-wage workers in larger firms would face the strongest incentive to sort into smaller firms to attract federal subsidies.

In sum, if the objective is to target the uninsured with low incomes, the most effective strategy is to target individuals and link federal tax credits to family income. Firm-based strategies that target low-wage workers are likely to miss a substantial number of low-income uninsured workers employed in larger firms, and they may direct subsidies to higher-income families. These proposals could provide incentives for individuals and firms to outsource workers from large to small firms. If true, this approach would result in higher federal costs per newly insured relative to proposals targeting individuals.

■ Structural Tax Reform Proposals

The structural reforms would allow employees to receive insurance through their employer or opt out and select a high-deductible plan and MSA. Under the opt-out provision, employees could purchase the high-deductible plan with pretax dollars from their employer. Although employers would continue to contribute toward the cost of insurance, fewer workers would receive coverage sponsored and organized by an employer. The structural reforms would also provide for a flat annual tax credit of approximately $500 per individual and $1,000 for families.[10] U.S. Rep. John Shadegg (R-AZ) has circulated one example of the structural reform. Several goals underlie the structural reforms. These goals are substantially broader than those

[10] *Bureau of National Affairs,* Health Care Policy Report *(February 15, 1999): 287.*

Table 3.5
Distribution of Workers[a] by Hourly Wage and Family Income as a Percentage of Poverty, 1997 (Millions)

Hourly Wage	0–100% number	0–100% percentage	101%–200% number	101%–200% percentage	201%–300% number	201%–300% percentage	301%+ number	301%+ percentage	Total number	Total percentage
Under $5	11.0	44.3%	5.6	22.6%	2.9	11.8%	5.3	21.3%	24.8	100%
$5.01–$10	5.7	13.2	14.0	32.3	10.9	25.2	12.7	29.4	43.4	100
$10.01–$15	0.7	2.3	3.2	10.4	7.2	22.9	20.2	64.4	31.3	100
$15 +	0.6	1.2	1.2	2.6	3.0	6.7	40.4	88.6	45.1	100
Total	18.0	12.4	24.0	16.6	24.0	16.6	78.6	54.4	144.6	100

Family Income as Percentage of Poverty

Source: Tabulations derived from March 1998 *Current Population Survey.*
[a]Workers defined as worked at *any* time during the year.

Table 3.6
Illustrative Impact of Cashing Out the Value of Employer-Sponsored Insurance

	Average Health Spending[a]	Per-Worker Employer Contribution[b]	Per-Worker, Actuarially-Adjusted	Age-Rated, High-Deductible Plan Plus MSA[c]		
				Premium	Per-worker basis MSA[c,d]	Actuarial basis MSA[c,d]
Incentive to Buy High-Deductible Plan						
18–24	$1,176	$2,240	$ 940	$ 756	$1,644	$ 744
25–29	1,430	2,240	1,142	918	1,482	784
30–34	1,624	2,240	1,300	1,044	1,356	816
35–39	1,960	2,240	1,570	1,260	1,140	870
40–44	2,352	2,240	1,881	1,512	888	936
45–49	2,996	2,240	2,400	1,926	474	1,034
Incentive to Stay in Employer Plan						
50–54	3,948	2,240	3,160	2,538	0	1,182
55–59	5,600	2,240	4,480	3,600	0	1,440
60–64	7,756	2,240	6,205	4,986	0	1,779
Mean	2,800	2,240	2,240	1,800	1,000	1,000

Source: Kenneth E. Thorpe.
[a]Premiums only, excludes out-of-pocket spending.
[b]Assumes employer contributes 80 percent of premium.
[c]Medical savings account.
[d]Includes contribution from employee share of premium.
[e]Includes contribution from employee share of premium.

pursued by those seeking a more incremental approach. One key objective is to promote choice and individual "responsibility" in choosing health insurance benefits. Power over insurance choice would be ceded from the employer to the workers. Thus, the structural reforms allow those with employer-sponsored insurance to select *where* they will receive insurance: through the employer, purchased individually, or in some version through an alternative purchasing entity such as a "Health Mart." The structural reforms also include tax credits aimed at covering more of the uninsured.

By design, the structural reforms would have a substantial impact on health insurance currently offered and organized by employers. These proposals would give workers a choice of continuing their coverage through their employer or taking the (pretax) employer contributions and purchasing a high-deductible plan with an MSA. The impact of this opt-out provision on employment-based coverage depends, in part, on the methodology used by the employer (and allowed in legislation) to cash out employer benefits. One approach would simply provide each employee the same amount per worker. This approach is similar to how employees contribute (i.e., a fixed amount per worker by type of coverage-single, family) their share of employment-based insurance. However, a uniform payment per worker would create strong incentives for younger, healthier workers to take the pretax cash payment and purchase a high-deductible plan (see table 3.6). For instance, a typical employer contributes approximately 80 percent of the premium for employee-only coverage—on average, approximately $2,240 per worker. This uniform rate masks substantial cross-subsidies within firms traced to community rating within the employment-based setting. For instance, a typical male worker age 60 incurs more than five times more medical spending than a worker age 25. In this case, the 25-year-old worker could take the pretax contribution of $2,240, add his after-tax contribution of $560, purchase a qualified high-deductible plan (for purposes of our illustration with a deductible of $1,800) for approximately $760, and have $1,644 to place in an MSA. At the other extreme, a 60-year-old worker would receive the same $2,240; yet even a high-deductible plan would be quite expensive, nearly $5,000 per year. The older worker likely would not cash out his

employer benefit. In this case, however, the average cost per worker facing the employer after the opt-out provision would increase substantially. This could result in some workers dropping their insurance. Moreover, if the criteria for minimum participation rate generally employed by health plans are not met, the employer could have difficulty even offering health insurance.[11]

Different results would occur if the employer used age, sex, and other adjustments such as geography in establishing the per worker cash-out. Under this approach, older, more expensive workers would receive substantially higher pretax employer contributions compared with younger, healthier workers. In this case, the 60-year-old worker would receive more than $6,200 in pretax income from the employer. Even after purchasing a high-deductible plan, he would have nearly $1,780 left to place in an MSA. In contrast, the 25-year-old worker would receive $940, allowing him to place only $744 into the MSA. Using an actuarial adjustment to the employer's insurance contribution provides broader incentives for more workers to opt out of the employer plan relative to a uniform contribution. In either case, however, the cash-out provision would have far-reaching implications for the future of employment-based insurance.

■ Comprehensive Reforms

A final set of reforms under discussion would eliminate the favorable tax treatment of health benefits. Instead, employer contributions would be treated as taxable income, both for personal income and payroll tax purposes. Although it is difficult to anticipate the dollar volume of new federal revenue resulting from these changes, a tax increase of this magnitude could generate more than $500 billion over the next five fiscal years (see the caveat concerning this estimate in footnote 1). The tax increase would provide additional funding for both the Social Security trust fund and the Medicare program. In addition, approximately $330 billion could be available to provide income-related, refundable tax credits for the uninsured.

In addition to treating cash wages and employer fringe benefits equivalently from a tax perspective, the comprehensive reforms would, arguably, provide a more equitable distribution of federal subsidies to the population. Some of these proposals would establish an income-related tax credit, providing 100 percent of the cost of insurance that would be phased out with higher incomes. Several proposals like this approach have been offered in the past.[12] Most recently, Rep. William Thomas (R-CA) has discussed a similar proposal.

■ Impact of the Tax Credit Proposals on the Uninsured

Several incremental and structural reform proposals have been introduced that seek to reduce the number of uninsured. Some of these proposals explicitly limit eligibility to the uninsured (i.e., the ACP-ASIM proposal), while some proposals would allow others to claim the credit as well. As highlighted above, the number of uninsured using the credits to purchase health insurance depends critically on the dollar value of the credit. As a general rule, to entice low- and moderate-income uninsured workers to purchase insurance, tax credits that cover the bulk of the cost of insurance would be required. The results presented in chart 3.1 highlight some of the challenges facing the tax credit proposals.

For illustrative purposes, chart 3.1 examines the likely percentage of the uninsured who would purchase insurance under four proposals. Several other proposals have also been advanced as well. [13] With respect to the uninsured, these proposals are:

- The ACP-ASIM proposal. This would provide a $2,800 tax credit per uninsured adult at the

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[11] *For instance, many states require that 75 percent of eligible employees participate in a group health insurance plan to ensure against adverse selection and jeopardize the plan's solvency.*

[12] *See, for example, Mark Pauly, Patricia Danzon, Paul Feldstein, John Hoff, "A Plan for Responsible National Health Insurance,"* Health Affairs*, Vol. 10, no. 1 (1991): 5–25.*

[13] *In particular, the BCBSA proposal noted above, as well as a proposal by Congressman McDermott (D-WA), which would provide a tax credit equal up to 30 percent of the cost of health insurance. The maximum income eligible for the credit would be $40,000 for joint filers and $25,000 for individuals. The credit would be phased out entirely at $50,000 for joint filers.*

poverty line and would phase down to $2,400 by 150 percent of poverty.
- The proposal of Rep. Charlie Norwood (R-GA), H.R. 1136. This would provide a $1,200 flat tax credit per adult, $600 per child, and up to $3,600 per family.
- The draft summary of Rep. Richard Armey (R-TX). This would provide a flat credit of $800 per adult, $400 per child, and up to $2,400 per family.
- The draft summary of Rep. John Shadegg (R-AZ).This would provide a $500 tax credit for those with self-only coverage and $1,000 for taxpayers with family coverage.

As each proposal provides a different tax credit, participation among the uninsured will also vary. Chart 3.1 presents range of expected participation among single adults offered each of the credits noted above. By assumption, these credits are compared with the cost of purchasing a "typical" employment-based plan, such as the Blue Cross and Blue Shield standard option currently available in the FEHBP. Three general results are evident. First, only the ACP-ASIM proposal would appear to enroll over half of the eligible uninsured. Second, the most effective alternative proposal is the one advanced by Rep. Norwood (H.R. 1136), which could enroll up to 26 percent of the eligible uninsured. Finally, the flat tax credits proposed by Norwood, Armey, and Shadegg would enroll a higher proportion of eligible, higher-income uninsured. In contrast, the ACP-ASIM approach would enroll a higher proportion of lower-income uninsured.

■ Conclusion

Reforming the tax system is the most recent *zeitgeist* concerning health care reform. Several proposals have been advanced that use the tax system as the vehicle for reforming health care. The proposals incorporate a variety of goals regarding health policy. The narrower, incremental proposals primarily target the uninsured. These proposals rely on tax credits to reduce the price of insurance, making it more affordable for low- and moderate-income families to purchase. A second wave of reforms, which I have called structural reforms, includes broader goals. In addition to targeting the uninsured, these proposals increase individual choice and power over where they receive their health insurance benefits. Allowing employees to "cash out" their employer contributions would fundamentally reshape our existing health insurance marketplace. The ultimate impact of such reforms on the existing employment-based system will depend on several key factors, including the method used to determine the employer contribution and the restrictions on how these contributions may be used.

The ultimate impact that tax credits have on reducing the number of uninsured depends critically on the details of the proposal. The comprehensive reforms would target all the uninsured. How and where Americans receive their insurance, what type of insurance, and at what rates are critical issues embedded within such proposals. The incremental and structural reforms would cover fewer of the uninsured. As the dollar value of the tax credit is low in several proposals, relatively few uninsured people are likely to participate in the program.

Several of these proposals include tax credits for children as well as adults. At issue is how these proposals complement, or compete with, existing federal law (i.e., Medicaid and Title XXI, the S-CHIP). In the final analysis, several of the incremental and structural reform proposals are likely to have far greater implications for those with insurance. These reforms would generate substantial numbers of financial winners and losers among the currently insured. Cashing out the employer contribution for insurance eliminates the current cross-subsidy in employment-based insurance among workers. Although more control would be provided directly to the worker, how workers respond to their changing economic opportunities in the health care market is uncertain. The creation of winners and losers as part of previous proposals about health reform has drawn strong opposition from consumers, ultimately contributing to their demise.

As noted above, the structural proposals also provide tax credits (although they apparently are not refundable or made available on an advanced payment basis). However, the dollar value of the credits is lower than those proposed by the ACP-ASIM in their incremental reform. As a result, fewer of the uninsured are likely to purchase

insurance. Moreover, because the credits are not limited to the uninsured, the credits would replace existing spending made by employers and employees today for health insurance benefits. The substitution of public for private dollars would increase federal costs without reducing the number of the uninsured.

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Individual Choice Initiatives: Analysis of a Hypothetical Model Act

by Donald F. Cox and Christopher Topoleski

Introduction and Summary

Employers are the primary source of health insurance coverage in the U.S. economy today. In 1995, about 148 million nonelderly individuals were covered by employment-based health insurance policies. In contrast, about 16 million were covered by other private insurance, about 38 million were covered by Medicaid and other public assistance programs, and 40 million were uninsured (Employee Benefit Research Institute, 1997).

Employers may decide to offer health insurance benefits to employees and their families for a variety of reasons. Firms have an interest in keeping employees healthy to reduce the use of sick leave and worker-replacement costs. Also, workers (especially more senior employees with firm-specific human capital) may value health and pension benefits more than wage income (Burman and Rodgers, 1994). Furthermore, through the combination of lower administrative costs and a broader group risk pool, employers may face lower insurance costs than those purchasing coverage in the individual market. This is particularly true for larger employers. Finally, employers are likely to be better at searching for lower-cost products than employees would be in the individual market. Even small savings in per-worker search costs would result in large savings in the aggregate (Morrisey, 1992).

The dominance of employment-based health insurance has, however, primarily been attributed to two factors. First, during World War II, wage increases were strictly controlled under price regulations. As such, employers offered health insurance benefits in lieu of wage increases. Second, in the early 1950s, the federal tax code was altered to exclude employers' contributions to health benefits from taxable employee compensation (Robert Wood Johnson Foundation, 1996). This allowed employers to avoid paying payroll taxes on health benefits and gave them an incentive to over-provide this benefit relative to other forms of taxable worker compensation. Furthermore, employees avoided being liable for both payroll and income taxes on employment-based health benefits. Estimates indicate that this exclusion reduces the cost of insurance to employees by upward of 40 percent to 50 percent for higher-income employees (Congressional Budget Office, 1994).

The favorable tax status of employment-based health insurance has been subject to criticism for a number of reasons.[1] Specifically:

- It is not horizontally equitable in that individuals receive different values of health benefits dependent on their employment status. Because individuals purchasing outside of the firm cannot receive the same tax exclusion, there are differences in costs across sources of coverage not attributable to differences in benefits, consumer characteristics, or other factors. Also, for employed individuals, the benefits increase with larger employer contributions.
- It is not vertically equitable in that the value of the benefit changes with income. Due to the progressive structure of the tax system, the value of the benefit increases with income.
- It gives incentives for individuals to over-consume health care. Because individuals do not face the full price of health care costs, they are

[1] *For more detail, see for example, Gavora and Moffit (1998).*

not sensitive to costs of their health insurance. As a result, they may purchase too much insurance and consume too many services.
- Finally, the exclusion of payments employers make toward health insurance reduces government tax revenues. In 1994, the Congressional Budget Office (CBO) estimated that the exclusion reduced tax revenues by about $74 billion dollars (Congressional Budget Office, 1994). More recently, it was estimated that the exclusion cost the government about $111 billion in 1998 (Sheils and Hogan, 1999).

In addition, the proportion of health insurance costs paid by employees has been increasing. For example, in 1988 employees paid for 10 percent of the cost of single coverage plans (U.S. Government Accounting Office, 1997). By 1996, employees paid an average of 22 percent of premium costs.

In recent years, concerns about the cost of health care coverage and a lack of consumer choice in the types of available coverage have spurred a number of proposed solutions. These proposals have focused on "leveling the playing field" between employment-based and nongroup health insurance. The general approaches used by these proposals consist of either equalizing the health insurance tax subsidy across sources of coverage or reducing (or eliminating) the subsidy currently afforded solely by employers.

The underlying principle of these proposals is the notion of individual choice. That is, empowering consumers to make their own decisions about the type and amount of insurance coverage purchased will result in lower health expenditures. This would come about through the combined effects of direct price competition and consumers faced with the full cost of the price of care.

Interest in individual choice approaches to health insurance first became popular during the early 1990s, a period of rapid growth in the costs of health care. Although the rate of increase in the cost of coverage has slowed in recent years, projections indicate that these costs will once again begin to accelerate (Smith et al., 1998; Congressional Budget Office, 1998). As such, individual choice models are again being considered as potential legislative proposals.

The purpose of this paper is to examine the potential effects of a hypothetical change in law on the number of lives covered by health insurance. This hypothetical act is consistent with the notion of individual choice in that it is primarily based upon changing the rules for taxing health insurance benefits.

Specifically, the hypothetical model act analyzed consisted of three components:
1. Elimination of income and payroll tax exclusions for individuals' health benefits (including the self-employed);
2. Elimination of the corporate income tax exclusion for private employers that sponsor health insurance and the payroll tax exclusion for all employers that sponsor health insurance; and
3. Implementation of refundable tax credits for individuals who purchase health insurance.

Two variations of this hypothetical act were modeled:

1. Applying it to only small firms (i.e., firms with fewer than 100 employees), and
2. Covering all firms, the self-employed, and others currently without insurance.

The results of our analyses indicate that enacting the hypothetical provisions contained in the Model Act would result in significant changes in the number of covered lives and the source of this coverage. Specifically, according to our estimates:

- Under the scenario that affects only small firms, the number of individuals covered by small employment-based insurance will decline from about 53.6 million to between 12.8 million and 14.6 million. The change in number of uninsured individuals was estimated to range from a decrease of about 1.2 million to an increase of about 7.7 million.
- Under the scenario that affects all firms and the self-employed, the number of individuals covered by employment-based insurance will decline from about 152 million to between about 68.9 million and 78.1 million. The number of uninsured individuals was estimated to increase by between about 0.2 million and 23.6 million.

The ranges in these estimates are attributed to both the assumed subsidization scheme and

assumptions about the proportion of income individuals are willing to spend on health insurance. Further, the disproportionately larger effects on small firms are attributed to the assumed larger price sensitivity of these firms and the lower average wages of employees in small firms relative to those of employees in larger firms.

A potential limitation of our analyses is that they focus almost exclusively on examining the effects of changing the tax-related provisions. It is reasonable to believe that actual legislative proposals would encompass additional features that affect the price and accessibility of health insurance. Although our analysis attempts to account for the effects of mandating guaranteed issue or imposing community rating, other provisions might also have substantial effects on cost of coverage in the individual market.

The remainder of this paper is organized into three sections: a description of the approach used by Barents Group in analyzing the effects of the hypothetical model act, a discussion of the results of our analysis, and a summary and discussion of our results.

■ Methods

This section contains a discussion of the approach, data sources, and assumptions used in analyzing the various model acts.

Description of Approach

A four-step approach was used for analyzing the potential effects of the model acts. This approach is consistent with a standard approach for performing analyses of legislative impact.[2]

Development of a Baseline Scenario—As a starting point, we developed a baseline scenario that characterized the current private health insurance market at the national level. This was necessary to establish a point of comparison for assessing changes in the current market due to implementation of the hypothetical model acts. The major components of this scenario included describing the following:

- The number of insured individuals;
- The source of coverage (e.g., employment-based, self-employed, individual market, etc.);
- Average premiums by market segment (e.g., large group, small group, individual);
- The number of employers offering health insurance; and
- Employers' share of premiums.

An obstacle to developing this baseline is the lack of data to determine the relative costs of equivalent insurance products between the group and individual markets. Data are available on the costs of products in the individual market. For example, a study funded by the Kaiser Family Foundation collected considerable information about insurance products in the individual market (Chollet and Kirk, 1998); however, these data exclude the costs of comparable products in the small and/or large group market.

The state of New Jersey has published estimates of differences in product premiums between the small group and individual insurance markets (New Jersey Individual Health Coverage Program Board, 1996). Based on a sample of three plans, these estimates indicated that for comparable products, premiums were between 2.7 percent and 6.8 percent higher in the individual market.

Others have estimated that products cost between 20 percent to 50 percent more in the individual market (Adamache and Sloan, 1984, Gabel et al., 1997). These studies, however, do not identify whether the comparison group is large groups, small groups, or some combination of the two, which limits the usefulness of these estimates.

We relied primarily on estimates by Hay/Huggins, an actuarial benefits firm, to estimate individual market premiums (Hay/Huggins, 1989). These estimates decomposed insurance company administrative expenses by group size.[3] For example, for firms of one to four employees, administrative expenses were estimated to be 40.0 per-

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[2] See Barents Group (1998) for another example of the application of this approach toward legislative impact analysis.

[3] It should be noted that the Hay/Huggins estimates were primarily based upon indemnity insurance products. To the extent that administrative costs of managed care plans differ from those of indemnity plans, these estimates would need to be adjusted. Unfortunately, for this analysis we were unable to obtain estimates of these managed care plan costs.

Table 4.1
Estimated Increases in Premiums to Purchase Comparable Insurance Products in the Individual Market

Firm Size	Average Percentage Increase in Premiums
Fewer than 100 Employees	11%
100–999 Employees	24
1,000 or More Employees	32

Source: Barents Group LLC.

Table 4.2
Payroll Tax Components and Allocation between Employers and Employees

Component	Employer Contribution	Employee Contribution	Total
Social Security	6.20%	6.20%	12.40%
Medicare	1.45	1.45	2.90
Total	7.65	7.65	15.30

Source: Barents Group LLC.

cent of incurred claims (of which 8.5 percent was due to greater risk and profits); for firms of 10,000 or more, they were only 5.5 percent.

For this analysis we assumed that administrative expenses in the individual market would equal the Hay/Huggins estimates for the one-to-four member group market. Based on this assumption and the Hay/Huggins' estimates of administrative costs by firm size, the estimated increase in premium costs to purchase comparable insurance products in the individual market were calculated by increasing the administrative costs to the one-to-four group market costs. The estimated premium increases used for our analyses are presented in table 4.1.

Specification of the Hypothetical Model Act—The Model Act was developed primarily through a review of the literature. In addition, discussions with individuals knowledgeable about individual choice initiatives were useful in formulating the hypothetical taxation provisions. The specific components of the Model Act are discussed in the section on the Analysis of the Hypothetical Model Act.

Estimation of Changes in the Cost of Health Insurance Coverage—Changes in the cost of health insurance will affect both firms and individual consumers. The most direct change will be in the after-tax price of insurance. A number of estimates have found that the effect of the current employer exclusion is to reduce the after-tax cost of health care by upward of 50 percent. This section briefly discusses the components of this tax effect and presents the estimates of this effect used for the analyses contained in this report.

Taxation Effects on Individual Employees—Wage compensation is subject to both payroll taxes and personal income taxes. Currently, the payroll tax is set at a constant rate of 15.3 percent for wage income up to $68,400. For wage income above this threshold, the payroll tax (i.e., Medicare) is a constant rate of 2.9 percent and is borne by both employer and employee. The allocation of these taxes between employers and employees by component is shown in table 4.2.

In practice, most economists argue that employees effectively pay both their and their employers' contribution through reductions in wages.[4]

Personal income taxes consist of three components: 1) federal taxes, 2) state taxes, and 3) local taxes. The federal tax system is designed to be progressive—that is, as taxable income increases, the marginal tax rate also increases. While some states also have a progressive tax system, others have a neutral (constant rate) system, or they do not impose an income tax at all. Most local tax rates appear to be a constant proportion of the state tax rate.

For calculating the effects of excluding firm-sponsored health insurance premiums from payroll and personal income taxes on the cost of coverage, the approach discussed in Gruber and Poterba (1997) was used. Specifically, they assume that employers are indifferent to whether worker compensation takes the form of health benefits or wage income. Also, they assume that workers fully bear employers' share of payroll taxes. As such, each dollar per worker spent on health insurance

[4] *See, for example, Pauly et al. (1991); Pauly (1994); and Krueger and Reinhardt (1994).*

by an employer is going to reduce a worker's wage income by $1/(1+$t_{ss}$), where t_{ss} is the Social Security/Medicare (i.e., payroll) tax rate. Further, the price of $1 in pre-tax employment-based health benefits in terms of after-tax employee income is equal to $1 x ((1-t-$t_s$-$t_{ss}$)/(1+$t_{ss}$)), where t and t_s are the respective marginal federal and state/local tax rates. As an illustration, if a worker was in a 28 percent federal tax bracket, an 8 percent state bracket, and payroll taxes were 15.3 percent, then the after-tax price of $100 in employment-based coverage would be $42.24.[5]

This step in the analysis involved calculating these changes in insurance costs. For individuals in firms that decide to continue to offer health insurance coverage, the change will be a function of the specific federal, state, and payroll marginal tax rates. For individuals in firms that opt to drop coverage, premiums in the nongroup market must also be factored into these calculations.

In addition, the Model Act contains a refundable tax-credit provision. The effects of this credit were taken into account in calculating the price of coverage to individuals under this hypothetical act. The specific subsidy mechanism that was used in this analysis is discussed below in the next section.

Finally, a second-round source of change in the cost of coverage that should also be taken into account is the change in premiums due to risk selection. For example, healthy individuals might opt to drop coverage, which would tend to increase average premium costs as the average health status of the risk pool declines. Alternatively, individuals covered through group policies are usually considered to be healthier than those in the individual market. Further, average health status is usually considered to increase as the size of the risk pool increases.[6] Therefore, if the majority of individuals covered by employment-based plans shifts to the individual market, it would result in a healthier mix of individuals and, hence, yield reductions in average premiums in the individual market.

For the present analysis, however, we did not explicitly account for potential changes in the composition of the risk pool on premiums in the individual market. Instead, we assumed that those obtaining coverage in the individual market have the same risk profile as those currently in the individual market.

Taxation Effects on the Self-Employed—The self-employed are also subject to Social Security (payroll) taxes and income taxes. As discussed below, however, they are currently able to deduct 45 percent of insurance costs from their taxable income. The after-tax price of insurance for the self-employed is calculated in a similar fashion to that for the employed, where the tax-advantaged portion of a premium is 45 percent of the total premium.

Taxation Effects on Others Purchasing in the Individual Market—As discussed below, individuals who are not self-employed but purchasing in the individual market are able to currently deduct the portion of health premiums in excess of 7.5 percent of their adjusted gross income (AGI) from their taxable income.

Estimation of the Behavioral Responses to Changes in the Cost of Health Insurance Coverage—Our approach was based upon an assumed sequence of behavioral responses to the changes contained in the hypothetical model act. Firms were assumed to respond first to changes in health insurance costs. Then, contingent upon how firm reactions might impact health insurance costs, employees would respond to these changes in prices (and the offsetting effects of any subsidy scheme that may be part of the model act) by either increasing, decreasing, or not changing the status of their health insurance coverage.

As this scenario illustrates, developing reasonable assumptions on firm and individual responses to changes in the cost of health insurance was of critical importance to this analysis. A number of sources of information were used to develop these assumptions, including a review of the literature and discussions with researchers and

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[5] *That is, $42.24 = $100 X ((1-0.28-0.08-0.153)/ (1+0.153)).*

[6] *Interestingly enough, at least one study of 28,990 firms has yielded estimates challenging this conventional wisdom (Young et al., 1995). This study found that the smallest firms (1–10 employees) and the largest firms (more than 1,000 employees) had the highest health care costs.*

Table 4.3
Estimates of Firm Price Elasticity of Demand for Health Insurance

Authors	Estimated Elasticity
Goldman and Pauly (1976)	–2.0 to –3.0
Jensen and Gabel (1992)	–2.6
Leibowitz and Chernew (1992)	–2.9
Thorpe et al. (1992)	–0.07 to –0.33

Source: Barents Group LLC.

policy analysts knowledgeable with the topic.[7]

One of the focuses of the following discussion is the "price elasticity of demand." This term refers to a key unit of measure for examining price sensitivity on the part of consumers. This measure relates a percentage change in price to a percentage change in the quantity consumed of a particular good. For example, an elasticity of –0.5 means that a 10 percent reduction in price will result in a 5 percent increase in the quantity demanded. Larger elasticity values, therefore, indicate greater price sensitivity.

Firms' Responses to Changes in the Cost of Health Insurance—As noted in the introduction, firms may offer insurance in response to employee preferences, to increase employee productivity, and to reduce employee training/replacement costs. In contrast, for some firms (especially small firms) the benefits from offering insurance are lower and the costs higher. For example, firms with higher worker turnover receive few (if any) returns to investing in worker health. Instead, the administrative costs of enrolling and disenrolling workers and underwriting costs are higher (Nichols et al., 1997). Further, for small firms there is more uncertainty and variation in premiums, which makes these firms more hesitant to offer a benefit that they might subsequently have to withdraw (Morrisey, et al., 1994). Also, the time costs involved in finding coverage may be nontrivial. For small employers, the most frequently cited reason for not offering coverage is price (Cantor, 1995).

Finally, some firms may not offer insurance simply because their employees may not demand it (Morrisey, 1992). A study of employees declining coverage from firms offering insurance found that these workers were very similar in observable attributes to workers at firms not offering coverage (Long and Marquis, 1993).

According to standard economic reasoning, increases in health care cost will be passed on to employees in the long run. This could occur through direct wage reductions, curtailment of other aspects of firm-sponsored benefits, or most likely through reductions in the rate of wage growth. The range of firm responses in the short run, however, is more complex. Faced with an increase in the cost of health benefits, firms could opt for one or more of the following responses:

- Pass increases directly on to consumers through increases in product prices,
- Reduce employee wages,
- Switch to less generous health plan offerings,
- Increase employee cost sharing,
- Stop offering health insurance coverage entirely, and/or,
- Reduce employment.

It is these short-run responses that have been the focus of most of the empirical studies on this topic. A particular focus has been the decision to drop (or adopt) coverage in response to price changes. Most of this empirical analysis has been on small firms. As illustrated in table 4.3, these studies have yielded a range of estimates. Even so, the consensus seems to be that most firms, especially smaller ones, are reasonably sensitive to changes in the cost of health insurance. For example, Leibowitz and Chernew's 1989 study of 950 small firms (with 50 or fewer employees) found that a 5-percent decrease in a firm's tax burden would increase the number of small firms offering insurance from 41 percent to 47 percent. Further, Jensen and Gabel (1992) found that a 5-percent increase in insurance costs due to state-mandated benefits would reduce the proportion of small firms offering coverage from 70 percent to 61 percent.

In contrast, one study of firms offering decisions found that subsidies do not have much of an impact on the coverage decision (Thorpe et al., 1992). It was estimated that subsidies of up to 50 percent would increase the number of firms offering coverage by between 3.5 percent and

[7] *More extensive reviews of the empirical literature on firm and individual price sensitivity are found in Morrisey (1992) and Andrews and Lake (1993).*

Table 4.4
Estimates of Individual Price Elasticity of Demand for Health Insurance

Author(s)		Elasticity Estimate
Taylor and Wilensky (1983)		–0.21
Homer (1984)	All Incomes	–0.16
	Income >$40k	–0.06
	Income <$15k	–0.39
Farley and Wilensky (1985)		–0.41
Marquis and Phelps (1987)		–0.20
Short and Taylor (1989)		–0.14
Manning and Marquis (1989)		–0.54
Marquis and Rogowski (1991)		–0.60 to –0.75
Gruber and Poterba (1994)	All	–0.69
	Single	–0.85
	Married	–0.60
Marquis and Long (1995)	Income <200% of Poverty Line	–0.21 to –0.40
	Income >200% of Poverty Line	–0.27 to –0.40

Source: Barents Group LLC.

16.5 percent. The authors attribute this lack of price sensitivity in part to limited information about the existence of the subsidization program and also to the short time period that it was in effect prior to their study.

Less rigorous evidence also suggests that larger firms may be less price sensitive than smaller firms. As reported in Morrisey (1992), a 1989 survey of small firms not offering health insurance found that 42 percent would offer health insurance if premiums were 20 percent lower. Also, some have argued that firms will not react to changes in costs until a certain threshold is reached (Robert Wood Johnson Foundation, 1996). One rule-of-thumb threshold put forth for firm reaction is 11 percent of payroll costs (Robert Wood Johnson Foundation, 1996). Firms may be reluctant to incur the costs associated with reacting to premium increases below that point. Because small firms typically pay lower wages and higher insurance premiums relative to larger firms, it stands to reason that a proportionately equal change in premiums would more likely result in a reaction from smaller firms than from larger ones.

Individual Responses to Changes in the Cost of Health Insurance. The literature on individuals' sensitivity to changes in the cost of health insurance is far more extensive than that for firms. As summarized in table 4.4, studies of individual health insurance purchase decisions have yielded a range of price elasticities. A number of factors contribute to this variation, including differences in the time period analyzed, the groups studied, statistical methodologies, and measurements of prices. In general, however, all of these estimates indicate that at the individual level, the demand for health insurance is not as price sensitive as that for firms.

These estimates also illustrate two other key points. First, price sensitivity varies with income. Lower-income individuals are far more sensitive to changes in insurance premiums than wealthier individuals. As illustrated in table 4.4, lower-income individuals can be between 50 percent to 650 percent more price sensitive than higher-income individuals. This is in large part due to the fact that insurance premium costs consume a far larger share of personal income as income declines. Some researchers have either empirically estimated or logically assumed that once health insurance premium costs exceed a certain proportion of income, insurance will be deemed unaffordable and consumers will not purchase it, irrespective of by how much premiums might have declined. In terms of budget share, this affordability threshold has been posited to be between 5 percent and 20 percent of income (Ku

and Coughlin, 1997; Gabel et al., 1997). Alternatively, others have used a poverty-level based threshold to determine the effective market for health insurance (Barents Group, 1996).

Second, price sensitivity varies by family size. As illustrated in table 4.3, married individuals have been estimated to be about 30 percent less price sensitive than single individuals. For a given level of income, one study predicted that married individuals have a predicted probability of purchasing insurance between 50 percent to 60 percent higher than single males (Marquis and Long, 1995). Further, for families with dependents, this study predicted a probability of purchase 73 percent to 88 percent higher relative to single males.

Data Sources

The three primary sources of data for this study were the March 1998 Current Population Survey (CPS), the 1996 KPMG Employer Benefits Survey, and the 1996 Small Business Supplement Survey, sponsored by the Robert Wood Johnson Foundation (RWJF). The CPS is a nationally representative annual survey of approximately 131,000 individuals. It contains information on individual, family, and household demographic and socioeconomic characteristics. The information specific to health care contained in this survey includes coverage status and source of coverage.

The KPMG survey includes 1,151 employers with 200 or more employees. The survey also includes a supplemental survey file on 1,560 firms with fewer than 200 employees. Survey respondents were asked more than 475 questions, mostly relating to health plan coverage.

Several additional sources of data were used to develop the project analysis file. First, a proprietary private data file was used for merging the employer survey data with the CPS data. Second, CBO estimates of health premium price increases were used to "age" the data to be representative of 1998 health insurance costs. Third, federal and state individual tax rates were obtained from various sources.[8]

The analysis file was developed in several steps. First, data on individual insurance coverage from the CPS were aggregated up to the family as defined by the tax filer. This was necessary to accurately associate taxable family income with insurance coverage. Second, the appropriate federal and state marginal tax rates for both AGI and taxable income were merged onto the file.[9] Third, the KPMG/RWJ premium data were updated to reflect estimated premiums for 1998. Fourth, the KPMG/RWJ data were merged onto the tax-family level CPS file. The appropriate insurance premium was assigned according to the combination of plan type (i.e., health maintenance organization, preferred provider organization, fee for service, point of service), firm size, industry, and region. The employees' share of premium costs was also merged onto the file so that we could correctly estimate the effects of the current tax exclusion and removing that exclusion on employee health premium costs.

Table 4.5
Assumptions Regarding Firm Price Elasticities

Firm Size	Price Elasticity
Less than 100 Employees	–2.6
100–999 Employees	–2.0
1,000 or More Employees	–1.3

Source: Barents Group LLC.

Key Modeling Assumptions

Throughout the above discussion, various modeling assumptions have been discussed either explicitly or implicitly. The purpose of this section is to clearly summarize the assumptions that were used in developing our estimates of the various hypothetical model acts.

1. Individuals will demand the same type of insurance that they currently have.
2. Individuals will face premium increases that are at most equal to current premiums in the individual market.

   Specifically, we assumed that individuals previously covered under employment-based insurance have the same risk profile as individu-

[8] *Federal personal income tax rates were obtained from the Internal Revenue Service 1040 Long Form. Federal corporate income tax rates were obtained from IRS (1998). State personal and corporate tax rates were obtained from Tax Analysts (1998), which is a collection of state tax statutes.*

[9] *Taxable income is AGI net of deductions.*

Table 4.6
Modeling Assumptions of Individual Price Elasticities

Income Relative to the Median Income	Single	Married	With Dependents
Greater than 25% below the Median	–0.60	–0.30	–0.15
Median +/-25%	–0.40	–0.20	–0.10
Greater than 25% above the Median	–0.20	–0.10	–0.05

Source: Barents Group LLC.

Table 4.7
Health Status Elasticity Adjustment Factors

Age	Factor Male	Female
<30	1.5	1.4
30–39	1.1	1.1
40–49	1.0	1.0
50–59	0.8	0.9
60–64	0.5	0.7

Source: Barents Group LLC.

als currently obtaining coverage in the individual market. As such, there will be no change in the relative cost of employment-based and nongroup plans for comparable products.

3. Firms will respond to increases in the cost of health insurance by dropping coverage.

For this model, we assumed that larger firms are less sensitive to changes in insurance premiums than are smaller firms. Our specific assumptions are reported in table 4.5.

The base elasticity of –2.6 was an approximate mid-point of the four studies discussed above. The fifth study (Thorpe et al., 1992) was not considered because of concerns about the reliability of these estimates. Firms with 100–999 employees were assumed to be 25 percent less price sensitive than firms of 99 or fewer employees, and firms of 1,000 or more employees were assumed to be 50 percent less price sensitive. Coding definitions in the CPS did not permit us to define the small group market in terms of the more standard definition of 50 or fewer employees.

4. Firms that drop coverage will provide employees with the full amount of the cost of coverage in the form of a wage increase.

According to standard economic reasoning, employers are indifferent to the proportion of compensation that is provided in the form of wages or other benefits absent tax considerations. The mix of compensation between wage and nonwage benefits is in large part determined by employee preferences and tax-based price distortions. In a competitive labor market, firms that drop health insurance coverage and do not provide an offsetting increase in other forms of employee compensation run the risk of losing their employees. For analytic simplicity, we assumed that this offsetting increase in compensation would entirely take the form of an increase in wage income.

5. Individual price sensitivity will vary by dependent status, family income, and health status.

We assumed that an individual's sensitivity to changes in the price of health insurance varied across income and family size. The specific price elasticities we used for this analysis were obtained by taking a mid-point estimate of the studies reviewed (–0.4) and adjusting for the number of dependents and income. We assumed that married couples were 50 percent less sensitive to price changes than singles and that families were 75 percent less sensitive. For differences across income, we assumed that lower-income individuals were 50 percent more price sensitive and that higher-income individuals were 50 percent less price sensitive than individuals around the median. These individual price elasticity assumptions are reported in table 4.6.

For examining the effects of guaranteed issue and community rating provisions, these base elasticities were adjusted to reflect the effects of varying health status on individual price sensitivity. It was assumed that relatively healthier individuals were more sensitive to price changes. The source of these adjustments was unpublished tabulations on relative utilization-based rating factors for a large commercial insurer. The health-status adjusted elasticities were calculated by multiplying the base elasticities in table 4.6 by the adjustment factors given in table 4.7.

6. Individual coverage decisions are also sensitive to the cost of insurance relative to total income.

We assumed that health insurance will not be purchased if the annual cost of insurance

Table 4.8
Hypothetical Premium Subsidy Schemes Used in the Analyses

Insurance Premium as a Percentage of Adjusted Gross Income	Percentage of Insurance Premium as a Refundable Tax Credit
Base Subsidy Scheme	
Less than 10%	25%
10% to less than 20%	50
20% or more	75
Accelerated Phase-Out	
Less than 2.5%	0
2.5% to less than 5%	15
% to less than 10%	25
10% to less than 20%	50
20% or more	75
Accelerated Phase-Out With Higher Refund Rates	
Less than 2.5%	10
2.5% to less than 5%	25
5% to less than 10%	50
10% or more	75

Source: Barents Group LLC.

under the model acts exceeds a certain percentage of an individual's or a family's reported AGI. For the estimates reported in this paper, we assumed two AGI percent thresholds—one at 8 percent of AGI and the other at 10 percent of AGI. For the few individuals and families that might currently pay more than these percentages of their AGI on health insurance, we assumed that if their premiums do not increase as a result of the Model Act, then they will not drop coverage.

Analysis of the Hypothetical Model Act

This section describes the components of the Model Act and presents our estimates of its potential effects on the cost of health insurance coverage and the number of covered lives.

Description

This Model Act calls for significant wide-sweeping changes in the private insurance market. The key features of this Model Act that we analyzed were as follows:

- Elimination of the income and payroll tax exclusions for individuals' health benefits (including the self-employed);
- Elimination of the corporate income tax exclusion paid for health benefits by private employers offering health insurance and the payroll tax exclusion for all employers offering health insurance; and
- Implementation of refundable tax credits for individuals purchasing health insurance.

Two variations of this hypothetical act were modeled: 1) limiting it to only small firms (i.e., firms with fewer than 100 employees) and 2) covering all firms, the self-employed, and other uninsured individuals.

A number of additional potential features of this act were not explicitly accounted for in our analysis. These features might include:

- Market-participation rules,
- Direct federal payments to health plans to subsidize coverage for low-income individuals, and
- Conversion of Medicaid to a voucher-based program.

Specification of the Subsidy Scheme—Subsidy schemes can vary along several dimensions. Direct subsidies, where the government directly subsidizes a share of the premium costs, could be fixed rate, variable, and/or targeted to specific groups. For example, in its 1988 pilot subsidy program, New York State used a 50 percent flat matching rate subsidy for small firms (Thorpe et al., 1992). Other direct subsidy approaches are based on the poverty level. For example, in Tennessee, Medicaid recipients are charged a sliding-scale premium up to 400 percent of the poverty level, whereas in Minnesota a sliding scale is used for up to 275 percent for families with children and 125 percent for those without (Schoen, Lyons, Rowland et al., 1997).

Another type of subsidy scheme involves offering tax incentives to purchase insurance. In general, there are three different variants to this approach. One variant involves making expenditures for health insurance deductible from taxable income. This, to a certain extent, is the approach used in the current tax code. The greatest criticism with this approach is that, because of the progressive structure of the tax code, it is regressive in that the value of the deduction is higher for higher-income individuals.

A second variant involves specifying a tax

credit, under which the individual can directly apply a portion of health premiums to his or her tax liability. This avoids the regressive nature of a tax deduction approach. Further, the amount of the tax credit can be structured so that it is phased out as income increases. The largest drawback with this approach, however, is that those individuals with little or no taxable income would not be able to fully benefit from the credit.

The third variant is a refundable tax credit. Under this approach, individuals would receive a refund if the amount of the tax credit exceeded their tax liability, which in effect solves the problem of the pure tax-credit scheme.

For the analyses reported in this report, we used three refundable tax-credit subsidy schemes. The first, or "base" subsidy is based on the subsidy contained in the Consumer Choice Health Security Act of 1994 (i.e., the Nickles-Stern Bill).[10] One of the alternative schemes was less generous than the base scheme, as it consisted of phasing out the subsidy for higher-income individuals. The other scheme was more generous than the base scheme, as it consisted of higher tax-credit amounts. These subsidy schemes are detailed in table 4.8.

Accounting for Guaranteed Issue and Community Rating—As noted in the above discussion, actual legislative proposals concerning individual choice would probably contain provisions regarding guaranteed issue and premium rating restrictions, such as community rating or rating bands. The effects of guaranteed issue and rating reforms have been examined in the context of group-to-individual conversions under the Health Insurance Portability Accountability Act (HIPAA), and, to a lesser extent, in the context of state-specific reforms. Depending upon the degree of rating restrictions (i.e., pure community rating versus rating bands), estimates of the effects of the HIPAA conversions on premium increases have ranged from as low as 1 percent (Klerman, 1996) to upwards of 22 percent (Health Insurance Association of America, 1996). As reported by the U.S. Government Accounting Office (GAO), the early experience of HIPAA implementation yielded premiums for guaranteed-issue products that were between 140 percent and 600 percent higher than standard rates (U.S. Government Accounting Office, 1998).

For the current analysis, we have assumed that the Model Act would include a guarantee-issue provision and a community-rating provision. In order to model the effects of these provisions, we

Table 4.9

Change in the Number of Lives by Former Source of Coverage Under Base Subsidy Scheme Firms with Fewer than 100 Employees

(thousands)

Former Source of Coverage	Current Number of Lives	Change in Number of Lives
Assuming Threshhold of 8 Percent of Familv Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–40,783
100–999 employees	30,873	0
1,000 or more employees	67,597	0
All firms	152,025	–40,783
Emplovment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–962
Construction	9,029	–4,486
Manufacturing	30,639	–4,632
Transportation, Communications, Utilities	13,454	–1,900
Wholesale Trade	6,406	–2,370
Retail Trade	14,248	–4,481
Finance, Insurance, and Real Estate	9,170	–2,230
Services	66,673	–19,722
Self-Employed	6,386	0
Individual Market	13,805	33,184
Uninsured	42,841	7,599
Assuming Threshhold of 10 Percent of Family Adjusted Gross Income (AGI)		
Emplovment-Based Coverage, by Firm Size		
Less than 100 employees	53,555	–39,066
100–999 employees	30,873	0
1,000 or more employees	67,597	0
All firms	152,025	–39,066
Emplovment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–923
Construction	9,029	–4,371
Manufacturing	30,639	–4,232
Transportation, Communications, Utilities	13,454	–1,845
Wholesale Trade	6,406	–2,341
Retail Trade	14,248	–4,301
Finance, Insurance, and Real Estate	9,170	–2,184
Services	66,673	–18,868
Self-Employed	6,386	0
Individual Market	13,805	39,126
Uninsured	42,841	–60

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

[10] *As described in Miller (1994).*

Table 4.10
Change in the Number of lives by Former Source of Coverage Under Accelerated Phase-Out Subsidy Scheme Firms with Fewer Than 100 Employees (thousands)

Former Source of Coverage	Current Number of Lives	Change in Number of Lives
Assuming Threshhold of 8 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–40,790
100–999 employees	30,873	0
1,000 or more employees	67,597	0
All firms	152,025	–40,790
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–962
Construction	9,029	4,484
Manufacturing	30,639	–4,632
Transportation, Communications, Utilities	13,454	–1,900
Wholesale Trade	6,406	–2,370
Retail Trade	14,248	4,483
Finance, Insurance, and Real Estate	9,170	–2,230
Services	66,673	–19,728
Self-Employed	6,386	0
Individual Market	13,805	33,126
Uninsured	42,841	7,664
Assuming Threshhold of 10 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–39,072
100–999 employees	30,873	0
1,000 or more employees	67,597	0
All firms	152,025	–39,072
Employment Based Coverage, by Industry		
Agriculture/Mining	2,406	–923
Construction	9,029	4,369
Manufacturing	30,639	4,232
Transportation, Communications, Utilities	13,454	–1,845
Wholesale Trade	6,406	–2,341
Retail Trade	14,248	4,304
Finance, Insurance, and Real Estate	9,170	–2,184
Services	66,673	–18,874
Self-Employed	6,386	0
Individual Market	13,805	39,061
Uninsured	42,841	11

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

Table 4.11
Change in the Number of Lives by Former Source of Coverage Under Accelerated Phase-Out Subsidy Scheme with Higher Refund Rates Firms with Fewer than 100 Employees (thousands)

Former Source of Coverage	Current Number of Lives	Change in Number of Lives
Assuming Threshhold of 8 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–39,355
100–999 employees	30,873	0
1,000 or more employees	67,597	0
All firms	152,025	–39,355
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–935
Construction	9,029	4,384
Manufacturing	30,639	4,301
Transportation, Communications, Utilities	13,454	–1,841
Wholesale Trade	6,406	–2,349
Retail Trade	14,248	4,318
Finance, Insurance, and Real Estate	9,170	–2,195
Services	66,673	–19,032
Self-Employed	6,386	0
Individual Market	13,805	38,792
Uninsured	42,841	564
Assuming Threshhold of 10 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–38,987
100–999 employees	30,873	0
1,000 or more employees	67,597	0
All firms	152,025	–38,987
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–923
Construction	9,029	4,365
Manufacturing	30,639	4,219
Transportation, Communications, Utilities	13,454	–1,838
Wholesale Trade	6,406	–2,341
Retail Trade	14,248	4,297
Finance, Insurance, and Real Estate	9,170	–2,181
Services	66,673	–18,822
Self-Employed	6,386	0
Individual Market	13,805	40,208
Uninsured	42,841	–1,221

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

used a two-stage process. In the first stage, the base model was estimated to determine who would obtain health insurance coverage. The relative risk profile of those obtaining coverage was then used to adjust premiums. Because a larger proportion of purchasers would have worse than average health status, this adjustment resulted in an increase in insurance premiums. In the second stage, the

Table 4.12
Change in the Number of Lives by Former Source of Coverage Under Base Subsidy Scheme, All Firms
(thousands)

Former Source of Coverage	Current Number of Lives	Change in Number of Lives
Assuming Threshhold of 8 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–40,783
100–999 employees	30,873	–16,809
1,000 or more employees	67,597	–25,450
All firms	152,025	–83,043
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–1,599
Construction	9,029	–6,127
Manufacturing	30,639	–16,101
Transportation, Communications, Utilities	13,454	–6,583
Wholesale Trade	6,406	4,277
Retail Trade	14,248	–9,374
Finance, Insurance, and Real Estate	9,170	–5,386
Services	66,673	–33,593
Self-Employed	6,386	–707
Individual Market	13,805	60,282
Uninsured	42,841	23,467
Assuming Threshhold of 10 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Less than 100 employees	53,555	–39,066
100–999 employees	30,873	–15,149
1,000 or more employees	67,597	–20,612
All firms	152,025	–74,827
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–1,443
Construction	9,029	–5,859
Manufacturing	30,639	–14,019
Transportation, Communications, Utilities	13,454	–6,120
Wholesale Trade	6,406	4,078
Retail Trade	14,248	–8,624
Finance, Insurance, and Real Estate	9,170	–5,049
Services	66,673	–29,635
Self-Employed	6,386	229
Individual Market	13,805	71,551
Uninsured	42,841	3,047

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

model was rerun using the adjusted premiums to generate our final estimates.

Estimated Effects

As noted above, two variants of this model act were analyzed: 1) limiting it to only small firms (i.e., firms with 100 or fewer employees) and 2) covering all firms, the self-employed, and others without health insurance coverage. For each of these variants we performed six simulations. These simulations differed in terms of the assumed income affordability threshold (i.e., 8 percent and 10 percent of AGI) and the structure of subsidy scheme (i.e., base scheme, accelerated phase-out, and accelerated phase-out with more generous subsidy levels).

As discussed below, the estimated changes in health insurance coverage were most sensitive to the form of the subsidy scheme. Under the base and accelerated phase-out schemes, the simulations indicated that there would be a net reduction in the number of lives covered by health insurance. In contrast, under the accelerated phase-out/more generous subsidy level scheme, the simulations indicated that there would be an increase in the number of covered lives.

Varying the AGI threshold also significantly affected the simulation results. This was in large part because the subsidy amounts increased with the share of AGI spent on health insurance. As such, an increase in the AGI threshold resulted in a disproportionately larger reduction in the number of individuals without insurance.

Small Firms Only Scenario—For this scenario we assumed that both the tax changes and subsidy availability would be limited to those employed in small firms. The results of our simulations are presented in tables 4.9–4.11. A central feature of this type of model act is making employment-based health insurance benefits subject to both corporate and personal income taxes. This is a very onerous increase in the total cost of health insurance because it represents moving from a system where health benefits are tax free into a system where they are effectively subject to double taxation.

The estimates of changes in employees being offered employment-based coverage reflect this large increase in costs to firms. As shown in table 4.9, under the base subsidy scheme between 73 percent and 76 percent of individuals in small firms with employment-based coverage were estimated to lose this coverage (depending on the assumed AGI threshold).

The majority of these individuals, however, will obtain coverage in the individual market.

Table 4.13
Change in the Number of Lives by Former Source of Coverage Under Accelerated Phase-Out Subsidy Scheme, All Firms (thousands)

Former Source of Coverage	Current Number of Lives	Change in Number of Lives
Assuming Threshold of 8 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–40,790
100–999 employees	30,873	–16,841
1,000 or more employees	67,597	–25,499
All firms	152,025	–83,130
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–1,601
Construction	9,029	–6,129
Manufacturing	30,639	–16,127
Transportation, Communications, Utilities	13,454	–6,587
Wholesale Trade	6,406	4,292
Retail Trade	14,248	–9,386
Finance, Insurance, and Real Estate	9,170	–5,395
Services	66,673	–33,612
Self-Employed	6,386	–708
Individual Market	13,805	60,202
Uninsured	42,841	23,636
Assuming Threshold of 10 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–39,072
100–999 employees	30,873	–15,185
1,000 or more employees	67,597	–20,664
All firms	152,025	–74,921
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–1,445
Construction	9,029	–5,861
Manufacturing	30,639	–14,044
Transportation, Communications, Utilities	13,454	–6,123
Wholesale Trade	6,406	4,093
Retail Trade	14,248	–8,636
Finance, Insurance, and Real Estate	9,170	–5,061
Services	66,673	–29,659
Self-Employed	6,386	222
Individual Market	13,805	71,478
Uninsured	42,841	3,221

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

Table 4.14
Change in the Number of Lives by Former Source of Coverage Under Accelerated Phase-Out Subsidy Scheme with Higher Refund Rates, All Firms (thousands)

Former Source of Coverage	Current Number of Lives	Change in Number of Lives
Assuming Threshold of 8 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–39,355
100–999 employees	30,873	–15,380
1,000 or more employees	67,597	–20,758
All firms	152,025	–75,493
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–1,469
Construction	9,029	–5,884
Manufacturing	30,639	–14,193
Transportation, Communications, Utilities	13,454	–6,083
Wholesale Trade	6,406	4,082
Retail Trade	14,248	–8,734
Finance, Insurance, and Real Estate	9,170	–5,112
Services	66,673	–29,937
Self-Employed	6,386	124
Individual Market	13,805	70,715
Uninsured	42,841	4,655
Assuming Threshold of 10 Percent of Family Adjusted Gross Income (AGI)		
Employment-Based Coverage, by Firm Size		
Fewer than 100 employees	53,555	–38,987
100–999 employees	30,873	–15,047
1,000 or more employees	67,597	–19,870
All firms	152,025	–73,904
Employment-Based Coverage, by Industry		
Agriculture/Mining	2,406	–1,432
Construction	9,029	–5,827
Manufacturing	30,639	–13,838
Transportation, Communications, Utilities	13,454	–6,023
Wholesale Trade	6,406	4,048
Retail Trade	14,248	–8,578
Finance, Insurance, and Real Estate	9,170	–5,005
Services	66,673	–29,154
Self-Employed	6,386	315
Individual Market	13,805	73,440
Uninsured	42,841	149

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

Although these individuals will face price increases due to losing the employment-based health insurance tax exemption, the effect of the accompanying refundable tax credit will negate a portion of this price increase. In addition, the presence of the subsidy reduces the cost of coverage to those currently uninsured, which reduces the number of previously uninsured individuals. As such, the change in number of uninsured individuals was estimated to range from a decrease of about 60,000 to an increase of about 7.6 million.

As noted above, the difference in the

Table 4.15
Summary of Modeling Scenarios, Total Lives by Source of Coverage (thousands)

	Employment-Based Coverage	Individually Purchased Coverage	Self-Employed Coverage	Uninsured
Baseline Estimates	152,025	13,805	6,386	42,841
		Only Firms With Fewer than 100 Employees Affected		
8 Percent AGI Threshold				
Base subsidy scheme	111,242	46,989	6,386	50,441
Accelerated phase-out	111,235	46,931	6,386	50,505
Accelerated phase-out With higher refund rates	112,670	52,597	6,386	43,405
10 Percent AGI Threshold				
Base subsidy scheme	112,960	52,930	6,386	42,781
Accelerated phase-out	112,953	52,866	6,386	42,853
Accelerated phase-out With higher refund rates	113,038	54,012	6,386	41,620
		All Firms Affected		
8 Percent AGI Threshold				
Base subsidy scheme	68,983	74,087	5,679	66,309
Accelerated phase-out	68,896	74,007	5,678	66,477
Accelerated phase-out With higher refund rates	76,532	84,520	6,510	47,496
10 Percent AGI Threshold				
Base subsidy scheme	77,198	85,356	6,615	45,888
Accelerated phase-out	77,104	85,283	6,608	46,063
Accelerated phase-out With higher refund rates	78,121	87,245	6,701	42,990

Source: Barents Group LLC calculations of the March 1998 Current Population Survey, Blue Cross and Blue Shield Association survey data, and health benefits survey data from KPMG LLP.
Note: Numbers may not sum to total due to rounding.

estimated numbers of uninsured between the 8 percent and 10 percent AGI threshold was in large part due to the structure of the subsidy schemes. Under all three schemes, the subsidy amounts increased substantially at 10 percent of AGI. As such, increasing the AGI affordability threshold from 8 percent to 10 percent resulted in a disproportionately larger number of individuals who could “afford” health insurance.

Similar results were obtained for the accelerated phase-out scheme (table 4.10). Under this scenario, it was also estimated that between about 73 percent and 76 percent would lose employment-based coverage, and the number of uninsured would increase between about 11,000 and 7.7 million individuals. The marginal difference in these estimates from those obtained in the base model is largely due to two factors. First, the phase-out will only affect a very small segment of the market (i.e., those with the highest income). Second, our model assumed that higher-income individuals would be less sensitive to changes in prices compared with lower-income workers. As such, the same price increase would result in a proportionately smaller coverage decrease in coverage for higher-income workers.

Finally, the accelerated phase-out/more generous subsidy simulation yielded lower estimates on the change in the number of uninsured individuals (table 4.11). Under this scenario, about 73 percent to 74 percent would lose employment-based coverage. Due to the generosity of this scheme, the simulations indicated that the number of uninsured individuals could decrease by about 1.2 million, or increase by about 0.6 million, depending on the assumed AGI threshold.

All Firms and the Self-Employed Scenario— Expanding the model act to cover all firms will result in proportionately larger reductions in the

number of individuals covered through firm-sponsored insurance. As with the small firm scenario, the majority of individuals no longer with employment-based coverage are estimated to obtain coverage in the individual market. Under the base subsidy scheme, in combination with the previously uninsured, the number of individuals with individual market coverage is estimated to increase by between about 60 million and 72 million (table 4.12). The number of uninsured individuals, however, is also estimated to increase by between about 3 million and 24 million.

The estimates obtained under the accelerated phase-out subsidy scheme were also consistent with those under the small-firm-only scenario (table 4.13). These estimates indicated a marginal increase in the number of individuals without employment-based coverage and the number of uninsured individuals.

Finally, under the accelerated phase-out/more generous subsidy, the net increase in the number of uninsured ranges from 0.2 million to 4.7 million individuals (table 4.14).

■ Summary and Conclusions

The objective of this paper was to attempt to characterize the potential effects of a hypothetical legislative change on the group and individual health insurance markets. As summarized in table 4.15, our analysis yielded a substantial range in the estimated number of individuals who would be covered by health insurance. Although all of the simulations indicated a reduction in the number of individuals obtaining coverage through employers, the number of individuals obtaining coverage in aggregate varied and was dependent upon the assumed-subsidy scheme.

The notion of affordability played a key role in the estimates. We assumed two AGI thresholds in developing the estimates. These thresholds were based on the limited empirical literature on this topic. If individuals are willing to spend a larger (or smaller) share of their incomes on health insurance, then these estimates would be proportionately affected.

Several additional observations are in order about these estimates. As is the case with all analyses of this type, a number of assumptions were made about the cost of coverage to the individual, the types of insurance products that are demanded, and the behavioral responses of individuals and firms to changes in the cost of health insurance. To the extent to which actual behavior deviates from our assumed behavior, the estimates reported here would be proportionately affected. For example, when individuals are confronted with substantial price increases for maintaining their current health insurance plan, instead of deciding to drop coverage entirely, they may instead opt for less-expensive plans with higher cost-sharing provisions and/or less-generous benefits packages. In fact, such behavior would be completely consistent with the notion of individual choice. Credibly modeling this type of behavioral response, however, would require more detailed information on the prices of alternative products and individuals' willingness to pay for more generous benefits packages than were available for the present analysis.

In addition, our estimates were predicated on a strong assumption about the cost of coverage in the individual market. If the risk profiles of those seeking coverage in the individual market is substantially less than those already in the individual market, or if efficiencies arise in the provision of coverage in the individual market, then premium increases would be less than those used in this analysis. If so, then the effects on coverage would be proportionately affected.

Lastly, we have not been able to examine the transition period between enactment and full implementation of this hypothetical act. This period is important. For example, in the short run firms may respond in very different ways to changes in health insurance costs. In particular, they may opt to reduce their work forces rather than drop insurance coverage. This could be an especially acute problem for industries with high concentrations of lower-skilled, minimum-wage employees.

In conclusion, the primary lesson to be learned from this analysis is a cautionary one of the uncertain effects of individual-choice initiatives on health insurance coverage. As noted, there are a considerable number of decisions that firms and individuals would have to make if such a law were enacted. Even when these decisions were limited, as in the case of our analysis, the potential range of changes in health insurance coverage was very

considerable. Determining the potential effects of the full range of decisions, therefore, would be subject to even more uncertainty.

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5

Understanding the Current Employment-Based System

by Jessica S. Banthin

Introduction

Some common themes run through the research and discussions in this book. William Custer[1] emphasizes the risk pooling benefits of the current employment-based system. Kenneth Thorpe[2] and Donald Cox[3] point out how difficult and expensive it would be to use tax credits to induce uninsured persons to purchase coverage. They also emphasize the fragility of the current system for risk pooling and how easy it is to begin breaking it apart.

Understanding the Current System

All of the discussions attest to the importance of understanding how the current system works before implementing new policies that might replace or diminish its role in providing coverage to the nonelderly population. For example, we know that the current tax exclusion is regressive, based on calculations that measure the value of the tax subsidy to families by income groups. That is, high-income families receive larger tax subsidies than low- and middle-income families. When the analysis is extended, however, to include the net value of health insurance benefits (premiums less insurance benefits) one sees a slightly different picture.

In a paper cited by two of the policy forum participants (Monheit, Nichols, and Selden, 1995/1996), it is shown that the tax subsidy offsets the losses that young, healthy, and high-income families would otherwise experience. The tax subsidy of employer-related health insurance is described as the "glue" that holds the risk pool together. Low-risk individuals and families are encouraged to participate in the employer-sponsored health insurance risk pool by favorable tax treatment and their participation benefits everyone else who participates, especially those with high risks—such as families whose members are in poor health or who have chronic conditions.

Would low-risk families drop their insurance coverage if the tax subsidy were eliminated? William Custer attempts to answer this question and finds that without the tax subsidy as many as 20 million adults would drop employment-related coverage. His analysis is consistent with the findings of Monheit, Nichols and Selden. The elimination of the tax subsidy would have the greatest negative impact on high-risk individuals and families, especially families with members in poor health, low- and moderate-income families, and workers in small firms.

Another way of understanding the benefits of the current system is that the tax subsidy works to minimize adverse selection within employment-based risk pools. A paper by Thomas Selden (Selden, 1998) shows that, in theory, a capped premium subsidy, such as a flat percent of the premium up to a cap, can work to mitigate adverse selection within a large employer system like the Federal Employees Health Benefits Program (FEHBP). The process by which a capped premium subsidy mitigates adverse selection within one employer pool is analogous to the way the current

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[1] *See William Custer, "The Tax Preference for Employment-Based Health Insurance Coverage," in this volume.*

[2] *See Kenneth Thorpe, "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured," in this volume.*

[3] *See Donald Cox, "Individual Choice Initiatives: Analysis of a Hypothetical Model Act," in this volume.*

tax subsidy encourages risk spreading over healthy and sick workers in all employer pools.

Erosion in the Current System

Despite the risk pooling benefits from the current employment-based system, we have to remember that these benefits are limited to those who are covered. We have seen how the existing tax subsidy induces low risks to buy coverage, thus expanding the risk pool across all sorts of families and ultimately benefiting high-risk families. At the same time, however, the current employment-based health insurance system is beginning to shrink. More and more employees are rejecting offers of health insurance coverage from their employers (Cooper and Schone, 1997). This is especially true of low-wage and low-risk employees—the young and healthy workers. They are beginning to opt out, and the tax subsidy is not enough to keep them involved.

We also have to remember that the current employment-based system is not one big risk pool. There are as many risk pools as there are firms. Some low-wage workers who work for large employers may benefit from a risk pool across all workers within the firm. But low-wage workers in small firms may not have access to a large risk spreading pool. They are less likely to be benefiting significantly from the current system.

Kenneth Thorpe's analysis is consistent with the notion of many risk pools. He presents tables that highlight how difficult it would be to target new subsidies to uninsured workers who are most in need. Although there is an association between low-wage workers and small firms, it is not as neat as we would like it to be. Neither is the association between low-wage workers and low-income families. That raises issues of directing base subsidies. He concludes that it would be less expensive to target subsidies to low-income workers than to small firms.

Thorpe puts reform proposals into three categories: incremental, structural, and comprehensive reforms. An example of a structural reform would be to offer medical savings accounts (MSAs) to all workers in the employment-sponsored system. In a recently published paper that I have done with some colleagues at the Agency for Health Care Policy and Research, we simulated this proposal. This paper (see Zabinski, Selden, Moeller, and Banthin, 1999) highlights two of the points I want to make. One is that the current employment-based system is not one big risk pool; there is a lot of variation within it. The other is that the risk pool is somewhat fragile and the introduction of new options like MSAs can unravel the pooling across healthy and sick families, resulting in a premium spiral that leaves comprehensive plans unaffordable.

In our simulation, we used detailed data from the 1987 National Medical Expenditure Survey (NMES), and were able to take account of people's current insurance plans and premiums. This allowed us to incorporate the wide variety of current coverage. We grouped people into seven risk pools according to the generosity of their coverage, whether it was a health maintenance organization (HMO) or not, and according to how large a premium load they faced. One of the assumed advantages of large employer group insurance plans is the low premium load (the load is defined as the extra charges above the actuarial value of the plan, charges related to administrative costs, profits, risk selection, etc.). In our paper we found that it is not always true that workers within the employer-sponsored system get good deals compared with, say, the nongroup market. Within the employment-based system we have today, some people, such as those who work for large employers, are getting good deals on their insurance premiums. Other workers are facing premium loads that, although not as high as the loads faced in the individual markets, are not generally a great bargain.

When we simulated the impact of offering an MSA to all of employees under age 65, we ended up with different results across risk pools. In most cases, however, the introduction of an MSA resulted in a premium spiral for existing plans. Healthy, low-risk workers were inclined to opt for the MSA option—that is, an MSA tied to a high-deductible plan. Workers in poor health (or whose family members were in poor health) were choosing to remain in the comprehensive plans. This, in turn, caused the premiums for the MSA-tied plans fall and the premiums associated with comprehensive plans to rise. In our simulation model, we allowed premiums to adjust in response to people's choices and then let people decide again which plan to

choose. We iterate over and over to an equilibrium. In four out of the seven risk pools there was a premium “death” spiral, that is the premiums for the comprehensive plans increased until no one could afford them and the plan essentially disappeared.

One of the conclusions of our MSA simulation analysis is that the current employment-based tax-subsidized system of spreading risk across workers is very sensitive to new options. It can fall apart easily, and this is critical to keep in mind when reforms are introduced.

In another simulation, Donald Cox’s very thorough analysis demonstrates the difficulty of using tax credits to induce uninsured to purchase health insurance. His results show that serious erosion of coverage can result when the tax subsidy is eliminated and replaced with refundable tax credits. In his simulation a lot of people opted out and the numbers of uninsured increased, depending on the scenario. The analysis was interesting because it incorporated health status and people’s sensitivities to prices and to new options. It was limited in that it did not allow for premiums to adjust based on people’s choices. Increased risk selection is may result when employer risk pools are disbanded—any simulation of the elimination of the tax subsidy should try to get at the issue of risk pooling.

Conclusion

What does this research tell us about policies for the future? Several papers point to the risk-pooling benefits of the current employment-based system for those who are insured, benefits which are supported by a tax exclusion valued at between $75 and $110 billion a year. Other papers point out the difficulty of encouraging uninsured people to participate in the individual market without significant tax subsidies. The research indicates that we need large subsidies to prevent adverse selection from fragmenting the existing employer risk pool. The research also tells us we need large subsidies to encourage increased participation among uninsured low-income families. Taken all together the conclusion seems to be that we need significant subsidies for health insurance markets of any type to effectively cover the nonelderly population.

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6

The Rationale for an Incremental Approach

by Congressman Benjamin L. Cardin

■ Introduction

Whether there are alternatives to employment-based insurance to meet the health needs of our country is a very important subject. This is what Congress should be considering in looking at the problems of the uninsured.

I am very biased on this subject. I now have served for 12 years in Congress. Before that, I was in the State Legislature, Speaker of the Maryland State Assembly, and I was partially responsible for the development of the Maryland all-payer rate structure for hospital reimbursement. It is the only one in the nation. We developed this structure in part because of the problems of the uninsured. We tried to deal with the realities of our society—the large number of people without health insurance. We did not want charity hospitals in our state; we wanted a system of high-quality access to all in our health care system.

■ The Uninsured: Higher Cost and Inefficiency

As you know, 43 million Americans lack health insurance. That is not right—for many different reasons. First of all, it is not fair; I do not like paying the cost for people who are uninsured and could be paying for their own health insurance. I am insured, and the cost to me is higher than it should be because I am paying for some people who simply decide that they do not want to pay for health insurance. Then, when they are in a car accident or they wrap their motorcycle around a tree and get flown to Shock Trauma in Baltimore, the cost of a couple hundred thousand dollars is later shifted to those of us who have health insurance. That is just wrong.

It also is inefficient and costly. As you know, people who are uninsured often use emergency rooms, which are very costly in many instances. The location of our health care facilities in large measure is dictated by where people have health insurance, again making the system less cost effective than it should be. So, we are overpaying. Shifting costs is not always possible. A facility is not going to locate in an area where many people lack insurance coverage because it cannot afford to run that financial risk. Today, managed care operators are looking to contract with more cost-effective, efficient facilities. If you have a large amount of uncompensated care and you need to shift the cost to those who pay, managed care plans are not going to use your facility. Thus, we have a system that is not only inefficient, but also unfair. It creates charity facilities, which are synonymous in many cases with a lower level of care. It denies access to quality care to all people, which we should have in our communities.

■ The Models for Universal Coverage

I support universal coverage because I believe it is what we need to do as a nation. Universal coverage would be more cost effective, would produce higher quality care, and would be more efficient. And, it is the right thing to do for our society.

I know of only three ways to get to universal coverage. We could develop a single-payer national model, an idea that many people have suggested over the years, which is gaining support among health care professionals. More doctors in my community in Baltimore favor a single-payer plan than ever before. They are tired of all the bureaucracies of all the different payers and would like to have just one bureaucracy. Even though they do not particularly like the federal government, they say, “Well, I prefer to deal with just one system, rather than all the different problems that

are out there."

I do not support a single-payer plan because I think quality would be sacrificed. The Health Care Financing Administration (HCFA) is located in Baltimore, and many of the dedicated men and women who work at HCFA live in my district. Some probably even vote for me, so I support HCFA. But I do not want to put all my eggs in one basket. I am not happy with the way the federal government micro-manages health care under the Medicare system, which is the only model that we have for comparison. If we use a single-payer system, it would be similar to Medicare, and I do not believe that would lead to the high quality care that we enjoy in our community today.

The second way to secure universal coverage is through individual mandates. Just tell everybody, "You have to find insurance." If you drive a car in Maryland, you have to have car insurance, right? Wrong. We have thousands, perhaps hundreds of thousands, of drivers in Maryland who have no car insurance. If we cannot enforce an individual mandate on car insurance, which is a lot less expensive than health insurance, I do not believe an individual mandate on health insurance in and of itself will solve the problem.

That takes us to employment-based health insurance. Although this book is designed to discuss alternatives to employment-based coverage, I believe employment-based health benefits are the best way for us to achieve universal coverage because they allow employers to be involved in health care policy in this country. They provide a dimension that has been partially responsible for the United States having the highest quality health care in the world, and I believe we are going to get more cost-effective health care. So, I am biased toward an employment-based system.

■ Charting an Incremental Course

At this point, we could end the discussion of alternatives and figure it out. We could go back to the Clinton employment-based model of 1993. Well, we went through that in 1993 and 1994, and we are not going to go through that again. We then went through 1995, which was a disastrous year for those who remember, with the partisan fights wherein the Democrats accused Republicans of destroying Medicare and the Republicans accused the Democrats of scaring the seniors. Both were right.

We charted a course in 1996, which was the right course, to make incremental change. America is not used to radical change overnight, so let us make progress where we can. We passed Kennedy-Kassebaum in 1996, which was a new chapter in cooperation on the Hill, and we have made major changes in our health care system. We adopted the State-Children's Health Insurance Program (S-CHIP), which provided coverage for millions of America's children who lacked health insurance. So, we are moving forward in an incremental way. Our goals are clear: We want to maintain high quality, the highest quality in the world. We want to bring costs under control. We do not want to see costs continue to escalate above the growth of our economy. These are two clear goals, and we have tried to implement them. The Balanced Budget Act of 1997 was a major effort to reduce cost. I have introduced a bill dealing with graduate medical education, which deals with quality.

In terms of universal coverage, how do you do it in an incremental way? The S-CHIP initiative is one way, and another is the President's Initiative to deal with young seniors, which expands the government insurance programs to places where the private sector has not been interested in providing coverage. I think that makes sense. Even though I support employment-based health insurance, I believe these programs are the way to go because there are going to be pockets in which we are not able to effectively get private interest. Therefore, I would support expanding government insurance to cover these populations.

The tax code has always favored employment-based health care, which makes sense. The tax code provides major incentives for employers to offer health insurance and for employees to want their employers to offer health insurance coverage. We have extended these incentives to the self-employed. We now will provide 100 percent parity to the self-employed, which will be phased in by the year 2003. I favor extending that type of tax preference to individuals who do not have health insurance offered through their jobs. Why should these persons be at that type of disadvantage? Why do we not offer them an opportunity at least to use

the tax code to become insured?

Let me provide some caveats to that approach. I favor tax credits, but they should be a supplement, not a substitute, to employment-based plans. We should not use them as a way to encourage employers to drop their existing health care coverage. But it is a little tricky as to how you do it. We also have to deal with the availability of private health insurance for individuals. It is not easy to find. In my own state of Maryland, we have passed small market reform, which is working well for employers with two or more employees. It does not work for the individual marketplace. We know that Aetna, the largest private insurer in the nation, dropped out of the individual market in 1989, saying it could not be profitable offering individual policies. In recent years, Aetna has purchased US Healthcare and New York Life's health insurance business; it is now trying to purchase Prudential's. These mergers have resulted in a large segment of the health insurance industry abandoning the individual market.

So we are facing another dilemma. Once we change the tax code to encourage individuals to purchase health insurance policies, how do we ensure they will be able to find an acceptable product in the marketplace that offers comprehensive coverage?

Then there is the issue of cost. Of the 43 million Americans who do not have health insurance, 33 million are either in the zero percent or 15 percent tax bracket. The tax code is not going to offer much of an incentive to those individuals. Of the uninsured, 43 percent are in families earning less than $20,000 annually. The policies that are generally available in the individual market are high-deductible, very costly plans. How are those families going to be able to afford health insurance?

So we have a problem out there. I am convinced we need to move in an incremental way, and we have to use the tax code and every other means we can to get more people insured because 43 million uninsured is unacceptable.

■ Conclusion

Our goal is clear—at least for the next several years: Figure out ways that we can chip away at those problems that prevent more people from being insured. As a result of these discussions and the employment community's willingness to stay involved with us in Congress on both sides of the aisle, I hope that we can find workable solutions to these problems. We need to provide affordable insurance opportunities for those who do not have employment-based benefits or who for other reasons are unable to find acceptable health care coverage. I am convinced that working together we can make significant progress in this area.

7

Reforming Health Care: Doing No Harm by Congressman John Shadegg

Introduction

I appreciate the opportunity to contribute to this book. I found a stunning amount of agreement between the position of Congressman Benjamin Cardin[1] and my position on a wide array of these issues, which provides a lot of common ground for discussion. I have to acknowledge, however, that I am one of those pariah Republicans who believes that we should reform the Employee Retirement Income Security Act (ERISA), and I have taken some heat from my business friends for taking that stand.

This is an incredibly timely topic, and I compliment the Employee Benefit Research Institute for taking it on. Paul Fronstin's discussion[2] provides not only a thoughtful analysis but a very balanced analysis of these issues, and these issues are critically important.

Value of Health Benefits

There is no doubt that employment-based health insurance has clearly served the nation well. As Paul Frontsin notes, workers both use and value their health benefits more than perhaps any other employee benefit they receive. That invites a cautionary note. When we embark upon reforms, perhaps we should take the doctor's admonition, "First, do no harm." And to the extent that the employment-based system is serving us well, we ought to not harm it.

In that regard, let me also make it clear that while I favor reforms, I strongly do not favor—indeed, I oppose—severing the tie between health insurance and employment, as least as I understand the term "severing." To create a dynamic in which employers stopped offering health care as an employee benefit would be very bad for the nation. Having said that, however, we need to look at this issue with an open mind. I think that, again as Paul Fronstin's report notes, there are both advantages and disadvantages to the employment-based system.

Today (May 5, 1999), I will be introducing—and I would love to get Congressman Cardin to co-sponsor—legislation that does much of what he proposed. It is called the Patient's Health Care Choice Act, a plan to provide choice, equity, and quality. This is a long-awaited bill. It has been discussed for several months, and we have worked very hard in writing this legislation to bring about some positive reforms without damaging the current system.

Two of the positive aspects of the current employment-based system that come most readily to mind are the economics of both pooling and group purchasing. These have served the nation well. They have helped to hold down costs, they have helped to spread risk, and they have been a great boon to the health industry and also to America's work force.

Disadvantages of the Current System

As public policymakers, Congressman Cardin and I have a duty to also look at what has not worked in that system—or the disadvantages. For example, the advantage of group purchasing, which provides economies of scale, currently works to benefit employers and employees of very large businesses to a certain degree and works to some degree of disadvantage to smaller employers and their

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[1] *See Congressman Benjamin L. Cardin, "The Rationale for an Incremental Approach," in this volume.*

[2] *See Paul Fronstin, "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion?" in this volume.*

employees. We have to think about that in terms of equity over time.

In addition, simply because employment is a natural pooling mechanism where people do not adverse-select or self-select based on health conditions, it is not the only pooling mechanism. Nancy Dickey[3] pointed out that there are other possible pooling mechanisms. She mentioned the American Automobile Association being a possible pooling mechanism, as well as the American Association of Retired Persons, and Vote U.S. These are just three examples of large organizations that, in fact, already offer other types of insurance to their members. But, of course, they do not offer health insurance.

One major issue that I think has affected many of us is the question of portability. Currently, the employment-based system it is not as portable as it might be. And in its worst aspect or worst permutation, you even have job lock. I have a sister, a seven-year survivor of breast cancer, who feels that she, herself, is locked into her current job with a school district in Arizona. There is a great deal of improvement in the area of choice, but it is true that a significant proportion of Americans do not have a wide array of choice in their current health care plans offered by their employers. What can we as public policymakers do about that?

There are two other issues with regard to disadvantages that perhaps we as policymakers could look at and improve without destroying the present system. These are the lack of a sense of personal responsibility, which is very important to me, and the last one is tax equity.

■ Personal Responsibility

While the tax code has encouraged and indeed subsidized employment-based health insurance, which has many advantages in terms of insuring America and keeping America healthy, it has had an unintended consequence. Many of those who receive their health insurance coverage through their employer tend to discount its value; they don't realize how much that is really worth. They also tend to look at it as a free benefit. All too often they ask themselves, "Well, why shouldn't I go to the doctor? After all, I already paid for it and it's free." Of course, neither of those statements is true. They have not already paid for that particular visit, particularly if that visit is not in fact necessary, and, of course, it is never free. So, those are aspects of the employment-based system that we should consider.

Perhaps one of the ways we can do that is begin to educate Americans about the value of the health care benefit they receive from their employers. Some people have talked about including that, and, indeed, we attempt this in my piece of legislation by including some of that information on the W-2 so that so that employees understand the real value of the health care benefit their employer is providing.

■ Tax Equity

The last issue is the question of tax equity. This is a major issue and it is an issue that was raised by Paul Fronstin and others—"What do we do about the uninsured?" I agree that the number of uninsured is the single largest problem we face in America today. The fact that the uninsured exist distorts the entire field because their health care is indeed being provided; it is simply not being paid for in a direct and accountable fashion.

As you know, the employment-based system results in employees of employers who offer them health care essentially getting health care that is at least partially subsidized by the government. Beginning with World War II, the tax code has said that if employers provide health care benefits to their employees, it is a deductible business expense to the employer and it is not income to the employee. That, of course, has produced the system we have today. While it has been beneficial, it also has tended to cause some distortions.

For all of the rest of America—43 million Americans by the latest count who do not get health benefits from their employer either because their employer does not offer health care coverage or because they are unemployed, it is a problem. We do two things to them that I believe we as policymakers need to address.

First we say to them, we are not going to subsidize your health care. We are not going to

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[3] *See Nancy Dickey, "Rethinking Health Insurance: The AMA's Proposal for Reforming the Private Health Insurance System," in this volume.*

allow you to get some kind of a deduction, which employers that provide health care get. On the flip side, we say, in a kind of a backhanded way, that in point of fact we are going to punish you if you are responsible and go out and buy health care because you are going to have to use after-tax dollars to do so. We can fix that, and we can do it without damaging or destroying employment-based health care. We can create tax equity in those circumstances, and we have tried to do that in the legislation that I have drafted.

■ Tax Credits

First, with regard to tax fairness for all, we provide a refundable tax credit to anyone who is not getting health insurance through their employer so that they can choose to buy health insurance. Only if they choose to buy health insurance are they eligible for the tax credit.

Let me make one point very, very clear: I said at the outset that I am not opposed to employment-based health insurance, and I do not think we ought to destroy the good of the current system. So, our tax credit is set at a relatively low level. Indeed, some people will criticize our tax credit and say, "That's ridiculous, Congressman. You couldn't possibly buy the kind of policy that people need for the dollars that are in your plan." But let me clarify what we are trying to do.

Our goal is not to insure with government dollars through a tax credit every single American who is uninsured. I agree with Congressman Cardin about an individual mandate or trying to get to that goal. But our goal is to provide tax equity so the tax credit in our legislation is set to provide roughly the same dollar value to Americans who do not get employment-based health care in terms of the tax credit as those, average Americans, who get employment-based policies. Get the government involved on an equal basis, and quit punishing the uninsured by saying, "You've got to buy it with 100 percent after-tax dollars."

The second thing, which Congressman Cardin touched upon in his remarks, is that we have added some market incentives and some improvements. Now the legislation includes association health plans, health marts, and individual membership associations in an attempt to try to provide more sources for people to get insurance.

The last piece of the legislation looks at the issue of choice. It says that if an employer chooses to (and I think largely this is going to be an issue embraced by small employers who are in a different position than large employers), the employer could allow employees to opt out of their system. If they did so, they could provide that employee with a dollar amount to purchase his or her own health care of choice. That money, which would follow the employee, would continue not to be taxable, just as the benefit currently is not taxable to those employees with employment-based insurance.

■ Conclusion

Our goal is simply to add choice and to give small employers, in particular, the option of discontinuing the business of procuring insurance for their employees. There are a number of reasons to move in that direction, and it is important to understand what they do.

First, it has the advantage of saying to Americans, "Make a careful evaluation of your employment-based policy versus what you might shop for—if you choose to and your employer allows you to shop for a policy. You may well discover that your employment-based insurance is better than you could get anywhere else in the world. So, you may stop complaining about what is wrong with your employment-based policy."

In addition, because it is at the employer's option, you are saying to America's employers that they can give their employees this option and let them take advantage of those market incentives, association health plans, health marts, and individual members' associations without destroying the current system in the process.

8

Rethinking Health Insurance: The AMA's Proposal for Reforming the Private Health Insurance System

by Nancy W. Dickey

Introduction

Since the end of World War II, the United States has relied primarily on a private, employment-based system to provide health insurance. The system served the nation well until the mid-1980s, when the number of nonelderly Americans with employment-based coverage began to fall and the country began to experience a steady increase in the number of Americans who are uninsured.

The erosion of employment-based insurance coverage and the general decline in the percentage of people carrying private health insurance—from 75.9 percent in 1987 to 70.7 percent in 1995—has spawned much concern across the nation. This concern was manifested in the protracted debate over the Clinton administration's health care proposal in 1992–1994, and is evident today in a number of proposals by congressional leaders to change the tax treatment of health insurance to make it easier for people to obtain insurance outside the eroding employer-based system.

Many side effects of the difficulties of maintaining a viable employment-based health insurance system are disturbing the public. "Managed care" has become the dominant mode of employment-based health benefits as employers have tried to clamp down on the cost of health benefits. Many of the methods used to restrict benefits, such as mandated maximum hospital stays, have precipitated a public backlash against managed care in the form of legislated constraints on its ability to impose many cost-saving measures. The politicization of the system is further illustrated by the fact that patient rights vs. managed care was a significant factor in the congressional and state elections of 1998 and will continue to be a volatile political issue.

The American Medical Association (AMA) has long supported the goal of universal access to health care for all Americans and has participated prominently in public policy debates about how to achieve the goal. Past attempts to achieve it have not been successful. Targeted public programs, such as Medicaid, leave many without protection. Schemes to work through the private insurance industry by regulating private insurance rates and mandating that certain benefits be included in private insurance policies have been counterproductive, actually reducing health insurance coverage on balance.

The AMA has a proposal to make necessary changes to laws and regulations to improve our system of health insurance. The proposed changes will expand the health insurance choices for all Americans, make those choices more affordable; preserve the advantages of employment-based insurance while eliminating many of the disadvantages; and redirect the public's subsidies of health insurance to make them more effective in significantly decreasing the number of uninsured Americans.

Only a few—but very fundamental—changes need be made to establish the legal framework for a vastly improved health care system. These changes will not force anyone to do anything they do not want to do, particularly if they are satisfied with the way things are now. Rather, these changes will open new doors to permit people to pursue new alternatives. The changes and their rationale are described in the

remainder of this paper. We hope that, after reading the paper, you will join with the AMA in advocating these changes.

■ Background

From 1987 to 1995, the percentage of people with employment-based coverage dropped from 69 percent to 64 percent. A number of factors have been cited for the long-term decline: falling real wages, displacement of manufacturing jobs with service-sector jobs in the U.S. economy, declining union membership, and increased use of part-time workers throughout the economy. Even in tight labor markets, the likelihood that smaller firms offer health insurance to employees is declining. A national survey conducted by Dun & Bradstreet found that in 1997, the proportion of companies surveyed (most of which had fewer than 25 employees) offering health insurance had fallen to 39 percent from 46 percent in 1996.

The number of workers actually accepting employers' offers of health insurance coverage is also declining. The decrease in acceptance rates is coincident with an emerging trend in which employers shift more of the cost of health benefits, such as health insurance premiums, to employees.

As times and conditions have changed, our traditional employment-based system of health insurance is serving us less and less well. Most of the uninsured U.S. population without health coverage is employed. According to the Current Population Survey, in 1996, 85 percent of the uninsured (35 million people) lived in families headed by workers, of whom 60 percent were full-year, full-time workers, and 26 percent were part-time workers. Among workers in the private sector, those in small firms were more likely to be uninsured than those in large firms. In 1996, 61 percent of uninsured workers were employed in firms with fewer than 25 employees. Of these, 24 percent of the self-employed were uninsured.

Americans' confidence in the future of the employment-based system is eroding. In response to a recent Employee Benefit Research Institute survey, only 40 percent of persons enrolled in managed care plans, which are the dominant type of employment-based coverage, report that they are confident that they will be able to afford health care without suffering financial hardship over the next 10 years. Only 27 percent of those enrolled in health maintenance organizations (HMOs) and 26 percent enrolled in preferred provider organizations (PPOs) are confident they will have access to quality health care over the next 10 years, while those who are confident they will be able to get the treatments they need comprise only 23 percent and 20 percent of the total enrollment in HMOs and PPOs, respectively.

Our reliance on an employment-based system of health benefits in the United States needs to be reconsidered. The laws and regulations that have fostered the employment-based system at the expense of other avenues for people to obtain health insurance need to be changed to let alternatives compete on a level playing field. Other laws that have placed the alternatives at a disadvantage, such as those that raise their prices beyond the realm of affordability for many Americans, also need to be changed or repealed.

■ Summary of the AMA Proposal

The AMA proposal has three main features.

First, a change in the tax treatment of health insurance is needed to make purchases of coverage outside the employer benefit system eligible for the tax subsidy and to increase the efficiency of the subsidy. Specifically, the AMA proposes replacing the current tax exclusion of employment-based health benefits from employees' incomes with a tax credit for each individual who purchases health insurance or who receives it as a benefit of employment.

Second, measures should be taken to rectify the disadvantages that have been placed on the individual insurance market. Mandates placed on insurers by the various state legislatures prohibiting underwriting practices and requiring insurers to cover many services that individuals would not choose themselves raise the price of private health insurance out of reach for many people. Such mandates should be scrutinized from the standpoint of their value to consumers. Other measures should also be taken to promote a more efficient and economical individual insurance market, such as fostering methods of pooling risk as alternatives to the employment-based group.

Third, the concept of employment-based health benefits needs to be broadened. While many

employers have converted from a defined benefit (DB) to a defined contribution (DC) approach to benefits, the full advantage of this approach cannot be realized by employees because the tax preference does not apply to insurance purchased outside the employer's benefit plan. The AMA calls on employers to 1) convert to DC health benefit plans by making a fixed-dollar contribution to their employees' choice of coverage, and 2) to offer the maximum feasible number of choices to employees. In addition, the AMA supports expansion of the statutory definition of health benefits to include employer contributions to employee purchases of health coverage in the private insurance market. This would allow employees to take the contribution that is, in reality, part of their compensation, outside the restricted confines of the employer's insurance offerings to shop for a better fit in the private market.

The specific details of the three main elements of the proposal and their rationale are discussed in turn below. The AMA realizes that some are skeptical about the wisdom of turning away from the employment-based system toward a system based on individual choice of coverage in the private market. Some of the issues often raised in the debate are discussed in the last section of this paper.

Revamping the Tax Treatment of Health Benefits and Insurance

The current tax treatment of health insurance creates a number of inequities and distortions in the market for health insurance:

- Currently, the government subsidizes health insurance by excluding expenditures on health insurance from an individual's or family's taxable income—but only if insurance is obtained as a benefit of employment.
- The tax exclusion subsidizes employees who receive health benefits from their employers, but it gives no such tax break to individuals who purchase their own health insurance.
- The discriminatory tax treatment of individually purchased health insurance puts it at a great disadvantage in the market, and it also perpetuates the employment-based health insurance system. Furthermore, the favorable tax treatment of employer-provided health benefits leads employees to want coverage for all of their ordinary, routine, and inexpensive health care needs. Because routine expenditures can be made tax free through the benefit system, their preferential tax treatment is a major cause of over-insurance and excessive growth in health care costs.
- The tax exclusion is also socially inequitable not only because only the employed are eligible for it but because it provides a higher subsidy for those with higher income. The subsidy is equal to 39.6 percent of the employer's contribution to employees in the highest tax bracket, while it is worth only 15 percent of the employer's contribution to employees in the lowest tax bracket. Furthermore, higher-income employees tend to choose more generous, expensive plans, thereby obtaining larger amounts of subsidy. Chart 8.1 shows how regressive the current tax exclusion is with respect to family income.

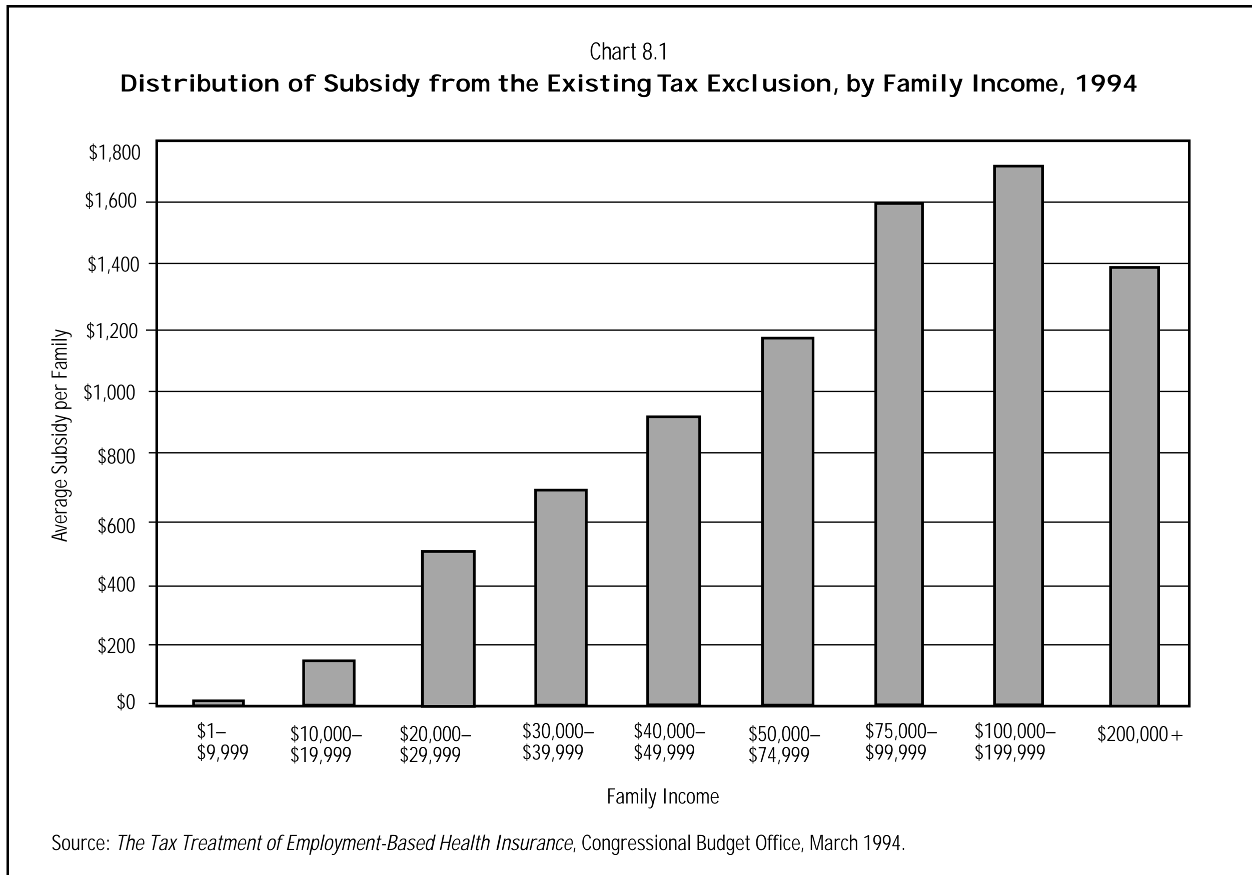
The core of the AMA's proposal for expanding access to affordable health insurance is revamping the tax treatment of health insurance expenditures, thereby creating an enabling environment for alternative sources of coverage and true competition among health plans. Our proposal would expand health insurance coverage by redirecting the current federal tax subsidy of health insurance toward those who need it most.

To correct the inequity and inefficient consequences of the current tax treatment of health insurance, the AMA proposes that the present exemption from employees' taxable income of employment-based health benefits, and of individual out-of-pocket expenses exceeding 7.5 percent of adjusted gross income (AGI), be replaced with a "refundable" tax credit for individuals equal to a percentage of their total amount spent for health coverage by individuals and their employers (up to a specified actuarial value or "cap" in coverage).

Changing the tax subsidy for coverage from an exemption to a credit would require neither new federal nor state bureaucracies nor a major change in the process of filing individual income tax returns. The change would not eliminate or reduce the employer's business expense deduction for any contributions toward employees' health coverage or increase their total compensation. It would be a

Chart 8.1

Distribution of Subsidy from the Existing Tax Exclusion, by Family Income, 1994



Source: *The Tax Treatment of Employment-Based Health Insurance*, Congressional Budget Office, March 1994.

straightforward matter to make the tax credit budget-neutral to the federal government.

The tax credit would provide a strong incentive for those who do not have insurance to purchase coverage because eligibility for the credit would be contingent on purchasing coverage. Relating the tax credit to income would tailor the federal subsidy to individuals' need for it and significantly increase lower income persons' access to adequate health coverage and reduce the extent of uncompensated care in our health care system. Making the tax credit "refundable" would assure that those who do not have sufficient current income to generate a tax liability would receive a subsidy for their purchase of health coverage.

■ Improving the Individual Insurance Market

Development of the market for individual health insurance has been retarded for a number of reasons. The two most important factors have been the Employee Retirement Income Security Act (ERISA) of 1974 and the imposition of coverage mandates by various states. These two forces have reduced the scope of the market for individual health insurance to a small fraction of the total volume of the market for health benefits, while at the same time the cost of individual coverage has increased beyond affordability for many individuals who have no access to employment-based benefits.

States have the authority to regulate insurance. However, ERISA preempts state regulation of employee benefit plans. ERISA allows employers to escape state regulation by self-insuring their employee health benefit plans. That is, they fund health benefits internally rather than through commercial insurance. This allows them to reduce costs by avoiding state benefit mandates and premium taxes, as well as contributions to risk pools and other state requirements that boost the cost of insurance. As a result of ERISA, it was estimated that between 117 million and 123 million nonelderly individuals were in ERISA plans in 1996. In contrast, only 16 million individuals purchased health coverage in individual insurance markets regulated by the states.

The individual insurance market is a

mixed blessing for individuals who do not have access to employment-based health benefits. In many states, people near retirement age or who have health problems are denied coverage or charged very high premiums. Many states have implemented “reforms” in attempts to lower the cost of coverage and prevent denial of coverage. The reforms include requiring insurance companies to guarantee issue and renewability of coverage, restricting exclusions for pre-existing conditions, requiring community rating, and mandating that insurers cover certain health services and certain types of providers.

Unfortunately, most such reforms have been counterproductive, actually causing the number of uninsured to increase in reform states, compared with states that have not enacted reforms. A study by the Heritage Foundation found that private health insurance coverage has actually declined in reform states; on average, the proportion of residents with individual insurance coverage in reform states fell from more than 10 percent in 1990 to less than 6 percent in 1996. A study conducted by researchers at the Urban Institute sponsored by Blue Cross and Blue Shield United of Wisconsin, also found that most state-initiated “reforms” of the small group and individual health insurance markets have resulted in fewer people purchasing private health coverage and more uninsured.

Thus, while our employment-based system of health benefits has been deteriorating, the incentives provided by ERISA for employers to avoid state-regulated insurance by self-insuring have weakened the markets for individual health insurance by diverting major volumes of economic activity away from them. Furthermore, attempts by many states to “reform” their individual health insurance markets have made matters worse by driving up the cost of private coverage and making it unaffordable to many individuals who do not have access to other sources of insurance. Therefore, if private insurance markets are to provide viable options for the increasing numbers of Americans who do not have access to employment-based benefits as well as to those who wish to expand their options by leaving the employment-based system, measures must be taken to rectify the disadvantages that have been imposed on private markets by federal and state legislation.

Concern with the situation has led some members of Congress to begin to design approaches to the problem. For example, Rep. Thomas Bliley (R-VA) is developing a proposal to create “HealthMarts,” which would be nonprofit risk-pooling cooperatives that would offer health benefits coverage to small employers and eligible employees. As currently described, HealthMarts would provide coverage through contracts with health insurance issuers including HMOs, PPOs, provider sponsored organizations (PSOs), and medical savings accounts (MSAs), and would hold annual “open seasons” for members. Health insurance offered through HealthMarts would be subject to state regulation, except that state requirements for coverage of specific types of providers and specific services would be preempted. HealthMarts would be permitted to make retrospective risk adjustments to premium payments to insurers to reflect differential risk of enrollees.

The AMA has long supported the development of health insurance risk-pooling cooperatives for the private market and applauds the positive movements toward implementing such a concept by the Congress. However, the AMA believes that risk-pooling cooperatives should be designed to fit into a broad reform plan in which tax reform provides individuals with tax credits for purchasing insurance. Therefore, the concept should encompass the following basic provisions:

- Make the products of risk-pooling cooperatives available to everyone, employees and individuals alike. By extending eligibility to employees of the largest firms, the risk pool would be improved. Similarly, extending eligibility to all individuals would allow them to participate in larger risk pools than are now available in the individual insurance market.
- Allow individual ownership of insurance to reduce “job-lock,” i.e., reluctance of employees to change jobs for fear of losing coverage.
- Allow premiums to reflect risk, so that insurance is not priced beyond the amount that low-risk individuals will choose to pay.
- Allow risk-pooling cooperatives to adjust payments to insurers to reflect the differential risk of their enrollees.
- Preempt state requirements to cover services of specific providers and specific goods and services.

Exempt insurance plans offered by risk-pooling cooperatives from state premium taxes and small group rating laws.

- Allow coverage to extend for unlimited time periods and extend the period between open seasons to reduce the opportunity for individuals to game the system and aggravate adverse selection problems.

■ Expanding the Definition of Employment-Based Health Benefits

One motivation for the risk-pooling cooperative concept discussed above is to facilitate small employers' provision of health benefits to employees by effectively pooling their risk with those of other small employers to reduce the cost of insurance. Under current law, employers are essentially prevented from doing this. A complementary approach, which would more directly empower employees in the individual insurance market, would be to amend current law to extend the tax treatment of employment-based benefits to employer financial contributions used by employees to purchase private insurance.

Sec. 106 of the Internal Revenue Code (IRC) limits the exclusion of employment-based contributions to health plans from an employee's gross income to employment-based coverage. This means that the tax exclusion cannot apply to an employer's contribution to an employee's purchase of coverage. Rather, such a contribution would be counted as taxable salary or wages.

This limitation has effectively restricted the ability of employers to offer employees a wide range of health coverage choices. Offering multiple options within an employer's benefit plan multiplies the expense of negotiating with health plans and administering benefits. Most employers who offer health benefits to their employees offer only one plan. According to a 1997 survey of employer health insurance supported by the Robert Wood Johnson Foundation, only 17 percent of those employers providing health benefits offer their employees a choice between two or more plans. Although larger firms are more likely to offer their employees a choice, the survey found that only one-third of firms with 100 or more employees offer them a choice of plans. On the employee side, less than one-half (41 percent) of employees who are offered insurance by their employer can choose among two or more plans.

One reason often stated for the backlash against managed care—which is now the most prevalent form of employment-based health benefit—is that individuals feel they are locked in to whatever plan their employer chooses and have no control over either the choice of plan or its decisions about their care. If they are not satisfied with the plan, they have little recourse except to resort to the political system for relief. Many employers, as well as employees, would like choice and control of health care transferred from the employer to the employee. But, as explained above, there are many restrictions on accomplishing this, including the definition of health benefits in Sec. 106 of the IRC.

A simple way to open the door to expanded choice in the increasingly unsatisfactory confines of the present employment-based system would be to expand the definition of benefits in Sec. 106 to include employers' contributions to employees' individual purchase of health insurance. Specifically, the AMA supports legislation that would extend the exclusion of employer-provided contributions to health plans from an employee's gross income to employment-based contributions to the employee's purchase of health insurance.

Such a change in the law would enable employers to convert their health benefit plans from a DB approach to a DC approach in which a fixed sum is provided toward the employee's choice of a health plan. This DC approach would allow employers to control their health benefit outlays with certainty. They would no longer have to intrude into the employee's consumption of health care or relationships with physicians and health care providers. From the employees' standpoint, such a change would allow the possibility of opting out of the employer-determined coverage to purchase coverage that is better tailored to their specific needs and preferences.

What would be the alternative sources of coverage in the private market? The concept of a risk-pooling cooperative, such as the HealthMart discussed in the previous section, is one such source. Legislation enabling risk-pooling cooperatives to offer insurance would greatly facilitate increasing choices for employees. However, there would very likely be many other sources of coverage that would enter the market spontaneously. Most

individuals are already members of groups that might begin to offer health insurance. Many of them already offer other kinds of insurance. For example, such groups as diverse as the American Automobile Association, American Association of Retired People, Boat U.S., and many federal credit unions are wide-based affinity groups that currently offer insurance products and might consider adding other insurance product lines if the law and the market permitted. Other existing groups, such as churches and professional associations, might also begin to offer health insurance policies to members. In general, it is likely that many groups would develop insurance products tailored to some predominant characteristics of their memberships.

Large affinity groups like those listed above might be even larger than most employer groups. Consequently, the advantages of pooling risk through large employer groups would not be lost but enhanced. The opportunity to join more homogeneous groups may motivate those who turn down employer offers of insurance and join the ranks of the uninsured to become insured outside the employer group.

Another simple action that would expand and strengthen the private insurance market would be to repeal the restrictions on the current MSA demonstration project authorized by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The program should be made permanent, and MSAs should be available to everyone with full latitude for the market to determine specific MSA product features, such as health plan deductible amounts, amounts of the contribution to the MSA savings account, and maximum annual out-of-pocket spending amounts.

■ Summary

The goal of the AMA's proposal for health system reform is to invigorate the private health insurance market as a viable alternative to the current employment-based benefit system, which is leaving a larger and larger number of workers without coverage and at the same time enjoys such favorable legal treatment that it prevents options from developing outside of it. Thus, the AMA calls for ending the tax and regulatory bias against individually purchased health insurance and creating an environment where individually owned insurance could be purchased economically.

Creating such an environment entails fostering the ability of employers and individuals to pool risk with others in the private insurance market. Risk-pooling cooperatives are often cited as a good device for facilitating such pooling in the private market. One example is Rep. Bliley's proposal to create HealthMarts, which are nonprofit risk-pooling cooperatives that would offer health benefits coverage to small employers and their eligible employees. However, the AMA believes that eligibility to join risk-pooling cooperatives should be extended to all who wish to purchase insurance in the private market.

Another action that would facilitate growth and development in the private market is to expand the definition of health benefits under Sec. 106 of the IRC to include employers' contributions to their employees' purchase of individual health insurance. Such an action would stimulate many affinity groups, many of which currently offer several types of insurance, to begin offering health insurance products to their members.

The tax exclusion of the value of employment-based health benefits from employees' gross income should be converted to a tax credit for each individual who receives coverage as a benefit of employment or who purchases health insurance in the private market. The tax credit would allow a more equitable and effective distribution of the federal subsidy of health coverage and would provide a powerful incentive for all Americans to insure against the possibility of incurring major health expenses.

Finally, the restrictions on the availability of MSAs should be repealed, as well as the restrictions that prevent vendors from tailoring MSA products to the market, such as mandated deductible and contribution amounts.

■ Arguments

This paper has presented the arguments for enhancing the private health insurance market as an alternative to the employment-based benefits system. There are, of course, those who argue against it. In this final section, the AMA would like to respond to some of those arguments.

1. The individual insurance market is dysfunctional; moving out of the employment-based system would be going from bad to worse.

AMA response: We agree that the favorable tax treatment of the employment-based sector and the harmful effects of state insurance regulation have retarded the development of the private insurance market. Our proposal is to repeal or change the legislation and regulations that have harmed the private market and made it dysfunctional so that it can become a viable alternative to the employment-based system, not to dismantle or destroy employment-based benefits.

2. One reason that private coverage is so expensive is that people seek individual insurance only when they are sick and go uninsured when they are well. How would your proposal prevent such gaming of the system?

   AMA response: A tax credit awarded to individuals who are covered under an employer's group benefits plan or who purchase private health insurance would serve as a powerful incentive for maintaining continuous coverage. Those who choose not to be covered will forfeit the tax credit, which most would probably not choose to do.

3. One reason that employment-based benefits are relatively inexpensive is that employers purchase in high volumes and also contribute to the cost in order to attract and retain good employees.

   AMA response: Economists believe that the notion that employers bear the cost of benefits is an illusion. Benefits paid by employers are part of employees' total compensation, which they would receive in wages and salaries otherwise. Employees can effectively increase their total compensation by taking the maximum allowable compensation in benefits, rather than salary or wages, because benefits are paid in before-tax dollars, whereas spendable salary and wages are reduced by income and payroll taxes. The AMA proposes that the tax breaks given to health benefits be converted into a tax credit for individuals who purchase private insurance or receive coverage from their employers. Our proposal would also make alternative pooling arrangements available to individuals, which could have even greater economies of scale than most employer pools can achieve, and therefore offer better rates.

4. Allowing employees to leave the group to purchase private insurance would result in only the sickest employees remaining in the employer's group and driving the cost up.

   AMA response: It is certainly true that expanding choices also has the potential of increasing risk segmentation or "adverse selection." There are several safeguards against excessive adverse selection that can be implemented. First, employers would continue to manage their benefit programs to control selection, and they would be foolish to let the situation described arise. For example, if employers retained a company health benefit plan, they could risk-adjust the amount of their contribution toward employees' purchase of health insurance outside the company plan to lessen the differential incentives for leaving or staying.

   Control of adverse selection would also be a managerial priority of risk-pooling cooperatives. The actuarial profession is well equipped to advise employers and private cooperatives on plan design that would keep adverse selection at an acceptable minimum. The HealthMart concept includes, for example, a provision allowing HealthMarts to adjust payment to health plans for the differential risk of enrollees. This provision would remove incentives for health plans to "cherry pick" the best risks and motivate them to give equal preference to high-risk individuals.

5. One benefit of employer groups is that the healthy subsidize the sick, making insurance affordable to all. In the private market, the sicker individuals would be subject to risk rating, which would drive their costs up.

   AMA response: The cross-subsidy of the sick by the healthy within employer groups is partially responsible for the trend of young, healthy employees becoming less likely to accept employment-based coverage as employers increase out-of-pocket costs to employees. Therefore, the cross-subsidy is increasing the number of uninsured employees. States that have imposed

cross-subsidy on the private insurance market through regulations requiring community rating have seen an increase in the number of uninsured. There clearly is a trade-off to consider in designing a cross-subsidy in an insurance plan.

There are a number of methods to maintain a degree of cross-subsidy in the private market. For example, payments to insurance carriers can be adjusted to reflect differentials in the risk of their enrollees.

Another approach to maintaining a degree of cross-subsidy is a modification of community rating that allows premiums to vary with health status, gender, age, claims experience, and other commonly used rating factors, while limiting the allowable range in variation from the average premium charged. Establishing such "rating bands" to limit the extent to which premiums for individual policies can vary may be a realistic and balanced way to ensure that policies are not priced beyond the means of those who most need them.

The AMA looks forward to a continuing dialogue with employers, business, Congress, and the public on this important issue. We are committed to achieving improvements in our health insurance system that benefit everyone in our society by increasing economic efficiency, expanding choices, and improving equity.

9

A Plan for Individual Health Insurance

by Stuart M. Butler

■ Rationale

Proposals to develop a health system based on individual insurance, such as the plan developed at The Heritage Foundation, and the ideas being discussed at the American Medical Association (AMA), are based on the premise that the principal cause of the gaps in coverage today is the inadequacy of the tax-favored, employment-based insurance system. Under the current arrangement for working-age families, employees receive an attractive tax benefit (a tax exclusion) if they allow their employer to allocate part of their compensation for a health insurance policy owned by that employer. (In certain cases, some out-of-pocket expenses, in a flexible spending plan, also are tax free.)

This arrangement helps to increase the number of uninsured in several ways. As the employer, not the employee, owns the plan, any change in employment status places coverage in jeopardy, and at the very least invariably means a change in coverage. If the worker is employed by a small firm, the plan typically is limited in scope and relatively expensive. Further, because the tax benefit applies only to employment-based coverage,[1] if the family chooses to gain the security and choice of individual ownership—even through a large, nonemployment pool—here is a large tax penalty. And by the nature of a tax exclusion, the largest tax benefit goes to the most affluent employee with the most generous plan, not to the lowest-paid employee with the highest share of out-of-pocket costs.

The Heritage approach seeks to deal with this root cause of the uninsured by changing the structure of tax relief for health care. In our view, any attempt to deal with the problem that continues to subsidize employment-based insurance, and merely adds new programs for families most disadvantaged by the current system, deals with the symptoms rather than the cause.

Under the tax reform proposed at Heritage, the tax exclusion and all other deductions for health-related expenses, such as the deduction for health expenses in excess of 7.5 percent of adjusted gross income (AGI) and the education for the self-employed, would be repealed. Instead, a new refundable tax credit would be created for unreimbursed medical expenses, including insurance, out-of-pocket spending, and contributions to a medical savings account (MSA). In addition, there would be certain changes in insurance law and employer responsibilities.

The tax reform, discussed in more detail below, would have three general effects.

First, it would make the tax system neutral with regard to the *method* in which a family paid for health care. Hence there would cease to be any tax advantage for otherwise uneconomic over-insurance, because families paying directly for all or part of their medical care henceforth would enjoy the same tax benefits as those paying via insurance.

Second, the tax system would be neutral with regard to the *source* of a plan. Thus a family deciding to own its health plan, either in the individual market or though a non-employment group, such as a union, church, or other affinity group, would receive the same tax relief as a family with an employment-based plan.

Third, the refundable credit would concentrate most assistance on those families with the highest level of health expenditures compared with family income. Unlike proposals for fixed percentage credits unrelated to income, the Heritage credit would function more like the

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[1] *Tax deductions are available to the self-employed and to taxpayers who itemize their returns, but for most employed individuals, the available deduction is in practice of little or no value.*

child care credit, with the percentage falling as incomes rise.

The insurance reforms, and the modest requirements on employers, would in addition ensure that insurance was available and that the credit system operated effectively.

Eligibility

All U.S. residents not eligible for Medicare would be eligible for the credit system, provided they and their family were enrolled in a federally qualified insurance plan. For a plan to be qualified, it may be a Veterans' Administration (VA), Federal Employees Health Benefits Program (FEHBP) or Medicaid program, or an insurance-based plan meeting at least the following standards:

1) **Minimum catastrophic coverage:** The plan must cover medically necessary acute medical care, including physician services, inpatient and outpatient hospital services and appropriate alternatives to hospitalization, and inpatient and outpatient prescription drugs. State insurance mandates would be pre-empted for federally qualified plans when the family chose to claim the credit. States could, however, offer or require federally approved risk-adjustment mechanisms to be incorporated into plans. The deductibles in a plan could not be greater than $1,000 per year for an individual and $2,000 for a family, and the total cost sharing for an individual or family could not exceed $5,000.

2) **Rating practices.** A plan could vary premiums only on the basis of age, sex, and geography, with the same rates applying to new enrollees as existing enrollees. Individual discounts could only be given for promoting health behavior, preventive care, or screening.

3) **Guaranteed issue and renewal.** Plans could not exclude from coverage, or limit coverage for, any pre-existing condition for anyone who had been covered for at least a year immediately prior to applying for coverage under the plan. For anyone not meeting that requirement, the plan could impose an exclusion equal to the number of months not covered before the application, up to six months. Plans also would have to renew coverage at their prevailing rates.

Subsidy Amount

The subsidy would be in the form of an above-the-line refundable tax credit. The credit could be claimed for the purchase of insurance (providing the plan met the federal minimum), contributions to a MSA (limited to $3,000 per year per family), and the unreimbursed cost of those medical costs eligible for the current tax deduction. The credit amount would be calibrated according to the following basic structure; however, the exact credit would be adjusted up or down, in proportion, such that the budgeted cost of the credit in the first full year of operation was equal to the budgeted savings from the repeal of current tax deductions and exclusions and the adjustment to state payments (see table 9.1).

Table 9.1
Tax Credit

Health Expenses	Credit (percentage of expenses)
Amount below 10% of Gross Income[a]	22%
Amount 10–20% of Gross Income	44%
Amount above 20% of Gross Income	66%

[a]Under the reform, gross income would include the value of all employer-paid health benefits.

Payment Method and Employer Requirements

In general, the credit would be made available to most individuals through the employment-based, tax-withholding system. Employers would be required to withhold from each employee's wages, unless the employee directed otherwise, the premium amount for the insurance plan chosen by the employee, if any,[2] and remit the amount to the insurer. In addition, the employer would be required to adjust the employee's tax withholding each pay period to reflect the employee's anticipated total refundable credit, much as tax withholdings are adjusted today at the discretion of

[2] *Employees would not be required to obtain coverage, and some employees would be covered by a spouse's plan.*

the employee for anticipated tax deductions, such as dependents and mortgage interest. For the withholding adjustment to be made, the employee would have to furnish the employer with proof that the family was covered by at least a federally qualified plan. The amount of withheld taxes remitted to the Internal Revenue Service (IRS) by an employer would be adjusted according to the total credits. The credit made available to the employee would be reconciled with the eligible credit in the family's annual tax return.

Self-employed individuals would factor the credit into their estimated tax payments, while unemployed individuals could claim the estimated credit for themselves and their families as a supplement to their unemployment insurance.

Employment-based insurance plans could remain in existence under the reform, provided a majority of employees voted to retain the coverage—in which case all existing and new employees would have to take coverage under the plan. However, employees could vote instead to discontinue coverage according to a collective agreement with the employer, including a negotiated maintenance-of-effort agreement specifying how existing health benefits are to be cashed out. An employer could decide to terminate a plan if there was no employee vote to continue coverage, but in this case the employer would have to demonstrate maintenance-of-effort by adjusting worker compensation by the value of the plan.

■ Benefits

Under the reform proposal, there would be no specified benefits other than that the minimum catastrophic protection for broad categories of care noted earlier. Actuarially equivalent benefits would be permitted under the catastrophic plans. States would not be permitted to impose additional benefits on plans deemed federally qualified and thus eligible as the base plan for claiming the credit. Thus states could not prohibit the marketing of a minimum plan. Families could, of course, decide to purchase additional coverage, and this could be regulated by the state. States could, however, require a risk-adjustment system for all plans, provided its application to the federally qualified minimum plan were approved by the federal government.

■ Determination of Eligibility

In general, the IRS would determine eligibility for the credit and the amount of the credit, with families or their tax preparers calculating the amount in the normal course of completing a federal tax return. The Department of Health and Human Services (HHS) would determine the specifications for federally qualified minimum plans and approve such plans, and the IRS would determine in the process of monitoring withholding and auditing tax returns if a family claiming the credit possessed an approved plan.

For the unemployed, the offices handling unemployment benefits would determine if the family met the eligibility requirements, including the possession of appropriate insurance, and calculate the credit. The amount of the credits provided through the unemployment system would be deducted from the amount the family could receive through the tax system. The uninsurance fund would receive a payment from the Treasury equal to the credits paid to unemployed individuals.

■ Flow of Funds

The intent is for the proposed reform to be budget-neutral at the federal level and to provide no windfall to the states. To the extent that uninsured or underinsured individuals in a state would opt for the refundable tax credit, rather than remaining uninsured or seeking to qualify for Medicaid, for instance, that state would realize financial gains by a shift of financial obligation from the state (or its local governments) to the federal government. Similarly, to the extent that uninsured individuals now turning to hospital emergency rooms would henceforth have insurance, states would accrue savings in programs to cover uncompensated care. For these reasons, the proposal envisions an adjustment to each state's federal disproportionate share funds, federal Medicaid payments, Children's Health Insurance Program funds, etc., equal to the calculated savings for the state in reduced costs for uncompensated care and other programs serving the uninsured. The amount would, of course, depend on the take-up rate for the credit program in the state.

Thus the funding for the credit system would come from two sources: the elimination of

"tax expenditures" associated with the repeal of the current exclusion and deductions for health care, and the relevant savings from current federal programs intended to support state spending for the uninsured. Under the plan, federal support to states would be adjusted to recoup the savings to states made possible by the credit, and the money would be used to help pay for the federal credit.

■ How the Credit Would Affect Households

Replacing the current exclusion and other health care tax breaks with a refundable credit system would have several financial effects on households. First, if the household had received employment-based insurance, henceforth these employer contributions to compensation in the form of health insurance would be added to an employee's cash income for tax purposes. On paper, this would appear on salary information as a cash wage increase. If the employment-based plan were dismantled, the employee would receive the cash. Second, this extra cash income would be subject to federal taxes.[3] Third, households would be responsible for the health insurance purchases that had previously been made by their employer, in part with the extra cash income they receive. In most cases, this would be through a salary-reduction plan at the place of work, with the money sent to the chosen plan. Fourth, households would receive a refundable tax credit for the purchase of health insurance or services, whether or not they received coverage through the place of employment.

■ How the Reform Would Improve Current Coverage

Changed basis of insurance. Unlike other programs that seem to supplement the current, deficient employment-based health system, the proposed reform deals with the root causes of the number of uninsured. And while radical, it would create a much simpler subsidy system for those currently insured as well as those without insurance. By delinking insurance ownership, the choice of plan and its coverage, and the subsidy amount from the place of employment, the reform would reduce "job lock" and anxiety among those currently insured. For the same reason, it would reduce future uninsurance—while today's employment-based system is virtually guaranteed to increase the number of uninsured.

Over time, the reform almost certainly would lead to a fundamental shift in the arrangement and nature of insurance, from a system in which families must effectively enroll in "monopoly" employment-based plans to one in which families could choose among plans typically offered through competing large affinity groups, such as unions or churches. These organizations would function as intermediaries in the purchase and delivery of health care; they would compete to act on behalf of families by assembling a package of care and acting as an insurance pool. In is significant that plans offered by unions and other employee-formed groups are a prominent feature of the FEHBP, the nationwide program for federal workers and retirees. The FEHBP allows eligible families to choose from a wide range of plans.

Furthermore, because the proposal would give families the power to choose and own their health plan and require plans to renew coverage, it would force insurers to compete for customers by offering families the best combinations of benefits, quality, and price, rather than—as today—competing often by offering employers ways to cut costs by restricting access. Thus insurers could be expected to devote far more attention to designing packages that meet changing patient demands, and consumer organizations could be expected to play a much larger role in reporting the differences between plans. Again, these are distinctive features of the FEHBP.

Children

The proposal would deal directly with the problem of uninsured and underinsured children. Because the tax credit is not connected to employment-based coverage and is available for out-of-pocket expenses as well as insurance, families could receive help to cover their children or pay directly for care. It seems likely, in fact, that specialized children's health plans, focusing on prevention and

[3] *It would also be subject to state income taxes in some states. Under the plan, we assume this windfall tax revenue is returned to taxpayers, perhaps through a state-level deduction for health expenses.*

routine care, would develop to supplement basic plans.

Low-Income Families

The refundable tax credit is designed to provide most help to low-income families facing high medical costs compared with their income. By reforming the tax treatment of all health care, the proposal provides funding for low-income families in a budget-neutral manner. And by providing the credit for out-of-pocket costs, not only insurance, it helps offset the cost of routine care that is costly to provide and reimburse through insurance.

People With High-Cost Illnesses

The proposal addresses people with high-cost illnesses in two ways. First, the underwriting restrictions would require plans to price benefits, and accept enrollees, without regard to their medical history. To be sure, plans would face selection risk by high-cost enrollees, as they would under any proposal with similar requirements. While the proposal does not address this directly, it would permit states to experiment with risk adjustment strategies and allow a secondary insurance market to develop.

The second way it addresses this group is similar to the way in which it deals with low-income families, namely by varying the credit. For families of identical income, a family with relatively heavy unreimbursed costs would qualify for a larger percentage credit to cover a higher proportion of its costs.

Early Retirees

Early retirees would be assisted by the neutrality of the tax credit and the personal ownership of insurance that would be the result of the plan. As the individual's employer typically would not own the insurance, an early retiree would simply leave employment with his or her insurance coverage, just as the individual's homeowner's or automobile insurance would be unaffected. If the former employer were required, under a previous agreement, to offset the cost of some retiree benefits, that would be a contribution to the retiree's plan and normally be counted as taxable income. The credit would apply to the total cost of the early retiree's care.

People between Jobs

Because a family's coverage under the proposal normally would not be based on the place of work, the family between jobs would face no greater problem with health insurance coverage than it would today with life insurance or any other coverage. In those cases where a worker had been employed by a firm in which the employees voted to retain employment-based coverage, the worker could elect to continue that coverage temporarily under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or could switch to another plan under the insurance rules discussed earlier.

During the period between jobs, the family would continue to be eligible for a credit to help offset the cost of coverage. Without an employer factoring the credit into the withholding calculation, of course, a person temporarily between jobs could not effectively obtain the credit, and would have to adjust withholdings in his or her next job—or wait until tax filing time—to obtain the credit for that period. If the individual were between jobs for some time and qualified for unemployment insurance, then the credit could be claimed through the unemployment insurance system.

■ The Politics of the Reform

The proposed reform reflects today's political constraints in several ways. First, it is a budget-neutral proposal. That necessarily limits the degree of assistance that can be provided in the form of the refundable credit. It also means that some upper-income people would face a tax increase. This does not mean, however, that each affected upper-income individual would necessarily feel worse off. Say the person currently had a very generous health insurance package and would actually prefer to receive more compensation in cash and less in health care. Under the proposal, this individual would in most instances have the opportunity to "cash out" part of the compensation now received as health care. Although this cash would now be taxable income, it would be considered the equivalent of a pay raise by the employee. Few workers resent a pay raise because their taxes go up. To be sure, this same worker would normally face a lower rate of tax relief on the value of his or her health insurance, but he or she would receive a

credit against out-of-pocket medical costs, although the total tax relief typically would be lower on balance. Whether or not the individual felt better off or worse off by the tax change would depend on his or her subjective assessment of these factors, not simply on whether the taxes paid went up or down.

The basic design does not require it to be budget-neutral, however, and so a variant would be to finance a more generous credit with other revenues or reductions in programs. A version of the refundable credit health credit introduced in 1993 by Sen. Don Nickles (R-OK) did include additional financing through spending reductions.[4] That legislation was designed such that the credit for low-income families was more generous than could be achieved with budget neutrality, and it left most upper-income families, on average, with no significant change in their tax bill.

Second, the general concern about the politics of taxes explains why this proposal includes no income limit on the credit or limit on the total credit. From an economic point-of-view, the case can be made that if a credit is to be given in place of the existing exclusion, it would be more efficient to make this available only for a certain level of coverage and to phase it out completely with income. But notwithstanding the economic argument, that would in practice mean a large tax increase for upper-income Americans, and many middle-income families—not something likely to be favored by Congress.

Third, enrollment in the credit program is voluntary. Making it voluntary recognizes the resistance to mandating private or state action in health care—and that resistance is particularly strong in this Congress. But this means that there would continue to be uninsured families under the proposal. It is not possible to say how many. In the proposal, the adjustment to federal programs providing states with help to offset uncompensated care recognizes that some families will not utilize the credit.

Fourth, there is no standard benefits package. The plan does include general requirements for a minimum catastrophic insurance plan if the credit is to be used—to avoid some families using the credit to pay for routine care while remaining uninsured, and then showing up at a hospital for care when serious illness strikes. But the proposal does not include specific benefits, and it envisions a variation in benefits. While this can be faulted as encouraging adverse selection, this concern is probably exaggerated, especially in light of progress in developing risk adjusters and in light of the experience with the FEHBP, which permits wide variations in benefits packages.[5] But by not including a standardized benefits package, it avoids the intense lobbying by provider interests at the federal level that would accompany a standardized package.

Fifth, the proposal is designed to operate through the place of employment for most people, even though it is not actually an employment-based system. This recognizes the familiarity of Americans with employment-based coverage, and that the place of work is the most convenient location for carrying out the financial transactions involved. A payroll-deduction system, modeled on the FEHBP, is attractive to most workers because it ensures that premiums are paid regularly, and blending the credits into the tax-withholding system is the easiest way for the tax support to be distributed as health expenditures are incurred. The proposal does place requirements on employers, but those are, in part, merely refinements of the withholding requirements already in law. And while requiring employers to offer the service of withholding premium amounts and remitting these to insurers is a new requirement, for most employers that would be far less onerous than running a health plan, as most do today.

Finally, the whole thrust of the proposal is to deal with the uninsured by providing families with greater choice and ownership rights, and, where necessary, with greater resources to obtain adequate health care and insurance protection. It does not expand government health care programs, as an expansion of Medicaid would do. It does not establish the government as the third-party payer as some proposals would do, and so avoids creating another case of insurers working for—and lobbying—an institution other than the covered family. And rather than merely taking action to deal with the deficiencies of the employment-based insurance system, it addresses directly the root problem of that system.

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[4] *S. 1743, The Consumer Choice Health Security Act.*

[5] *Moreover, the FEHBP does not even allow risk-based premium adjustments envisioned in this proposal, yet it is stable.*

10

View From a Think Tank

by Stuart M. Butler

It's time to form another health care system that could operate in parallel with employer-sponsored insurance.

In recent years, several industries and institutions have undergone profound transformations, often when long-overdue policy changes removed legal obstacles to innovation. Think of the revolution in telephone and television. Or the reform of welfare, which changed incentives for caseworkers and beneficiaries and triggered a dramatic fall in caseloads. And think of how different the health care industry is today compared with just 10 years ago.

It is time to contemplate an equally profound change in the employment-based health system for working Americans. That system certainly has well served the interests of millions of families—but for millions of others it works badly or not at all. For these latter families, it's time to remove policy roadblocks to the formation of another health care system that could operate in parallel with employment-based insurance.

■ Employer Coverage Fails to Protect Many

There has been a startling increase in the number of Americans without health insurance. The figure is over 40 million, with about one-third of Hispanics and half the working poor lacking insurance protection. The inescapable fact is that the employment-based system is completely failing these people, even if it is working well for the employees of Ford and AT&T. And it's failing them for some rather simple reasons. One is that Americans today are more mobile and less firmly attached to their places of work. So an employment-based health insurance system necessarily means frequent changes or interruptions in coverage.

Another reason is that one good characteristic of coverage in major firms—large, stable insurance pools with management economies of scale—breaks down completely for small firms. The Hay Huggins coverage survey for 1998, for instance, found that overhead costs for firms with fewer than 10 employers exceeded 35 percent, compared with about 12 percent for firms of over 500.

Americans who work for small firms unable to organize insurance nevertheless often have a stable, long-term affiliation with some large institution—one that is much better placed than their employer to assemble a large insurance pool with low management costs. Many uninsured Americans, for example, are closely connected with their churches or synagogues. Many religious organizations are highly sophisticated and heavily engaged in housing, education, and financial activities. Other uninsured families are affiliated with unions or other organizations.

The reason these institutions do not typically step in to fill the huge gaps in the employment-based insurance system is that the tax code is a massive obstacle. Today there is an enormous individual tax break for health care, worth approximately $100 billion in total taxes (about $1,000 for the average family). It takes the form of the exclusion from taxable income (including federal income tax, payroll, and state or local taxes) of all compensation devoted to employment-based insurance. The snag is that there is no comparable tax break for coverage provided through another organization, even when that coverage would make far more sense for a particular family. Put another way, the tax code has become a multi-billion dollar roadblock to innovative methods of organizing coverage for millions of families who are not served at all by employment-based insurance.

It's also worth noting that the design of this tax break has fanned popular resentment—quite unfairly—against managed care. The reason

is that tax-free employment-based insurance must be owned and controlled by the employer, not the employee. Covered workers cannot exercise the same direct control over their health insurer as they do, say, over the money going into their 401(k) plan. So they become understandably frustrated and angry when someone else—a health plan answerable to their employer—gets to make critical decisions about coverage trade-offs. The result: demands that the government or courts stop insurers and managed care plans from making such decisions.

■ Various Proposals for Reform

The tax code-induced obstacles to filling the glaring gaps in employment-based coverage have led many organizations and many lawmakers—from liberal House member Jim McDermott (D-WA) to conservative Rep. Bill Thomas (R-CA)—to propose new tax credits for working families obtaining insurance outside the place of work. Details vary, and some proposals would make the tax credits "refundable," meaning that families paying little or no tax would in effect receive a voucher to help pay for coverage. But all the proposals seek to level the tax subsidy playing field, enabling those without access to employment-based plans to get help toward coverage from some other source.

Two things need to be made clear at the outset about such ideas. The first is that a tax break for "individual" coverage does not mean people would typically obtain it in today's individual insurance market. The aim instead is to foster nonemployment groups, such as those based on unions or churches, by removing the tax obstacle.

The second is that creating an opportunity for nonemployment-based coverage does not mean declaring war on successful company-based insurance. It means addressing those cases in which employer coverage has failed. To be sure, some proposals envision a complete overhaul of the tax system to end any advantage at all for employment-based coverage. Understandably, many employers feel this would undermine good plans run mostly by large employers, leaving many workers worse off. That's why less radical proposals, such as McDermott's, would help those lacking company-based coverage but not touch the current tax treatment of employment-based health benefits.

■ Move Slowly and Cautiously

One way to reduce the risk to good employment-based coverage would be to place "walls" around successful employment coverage while other methods are encouraged and tested. The integrity of existing insurance pools could be preserved, for example, by *not* allowing employees to "opt out" of an employment-based plan just because a credit was available.

It makes sense to move slowly also because we need to learn more about nonemployment-based pools before we can say they could be a sensible and stable substitute for employment-based coverage rather than simply a vehicle to help cover today's uninsured. It may be necessary, for instance, to require people to enter into a long-term contract with, say, a church-sponsored insurance plan in order to keep the pool stable. Similarly, there needs to be much more experimentation in ways to deal with non-random risk selection though risk-adjustment tools.

On the other side of the coin, it's also time for business leaders to think creatively about making successful company health plans available to nonemployees. Let's remember that it is quite common for a corporation to turn a successful part of its business into a separate operation. The Sprint long-distance telephone company, for instance, grew out of The Southern Pacific Railroad's internal communications system. If the tax system helped uninsured workers to buy their own coverage, today's leading company-based health plans could widen their markets, generating profit by serving groups of nonemployees.

The idea of individual health coverage through nonemployment groups thus means the kind of paradigm shift that accompanies all major innovations within institutions or industries. Thinking about such changes always raises questions and concerns, and these must be addressed as we begin to remove the artificial tax impediments to what should be a natural evolution of health coverage to reflect the evolution of employment patterns in America.

But there does have to be change. A system that leaves 40 million of our people without the protection and certainty of health insurance is a failing system in need of structural reform.

11

A Critique of Individual Health Insurance Proposals

by Thomas Rice

Introduction

This discussion is divided into three parts: a description of individual health insurance proposals, their advantages, and concerns about them.

A Description of Individual Health Insurance Proposals

This paper is based on two documents that I have reviewed: "A Plan for Individual Health Insurance," by Stuart Butler of the Heritage Foundation, and "Empowering Our Patients: Individually Selected, Purchased, and Owned Health Expense Coverage." This was adopted by the American Medical Association House of Delegates in June 1998, based on its Council on Medical Service Report 9.

Note one key difference between the Butler proposal and the proposal by the AMA.[1] Under the Butler proposal, health insurance would be divorced from employment. Instead, individuals would purchase coverage for themselves and their families directly from health plans. They no longer would be able to deduct their medical expenses from their income taxes, but they would receive a refundable tax credit for health spending used to pay for insurance premiums, other out-of-pocket expenditures, and contributions to a medical savings account (MSA).

Health plans would be subject to certain rules, such as providing a minimum array of covered services, maintaining deductibles and copayments below a certain level, and employing an adjusted community rating (premiums could vary only by age, sex, and geographic location). It is anticipated that affinity groups, such as unions, would serve as intermediaries in the dissemination of information, as well as for the purchase and delivery of care for members. Employees could vote to keep their current employment-based health plan. Alternatively, they could choose to dissolve it, with the understanding that the employer would increase their cash wages by the amount of an employer's contribution level.

The key to the proposal is the tax credit used to offset medical spending. The credit is "refundable," in that it will be given in cash if it exceeds a person's income tax liability. Under the Butler proposal, the credit would be 22 percent of medical expenses for health-related spending up to 10 percent of income; 44 percent for spending between 10 percent and 20 percent of income; and 66 percent for spending above 20 percent of income. Funding for the tax credit would come from the savings that would accrue from eliminating current "tax expenditures"—primarily the deductibility of employers' premium payments for health insurance—as well as from "the relevant savings from current federal programs intended to support state spending for the uninsured."

The AMA proposal differs with respect to the nature of this refundable tax credit. Rather

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[1] *Dr. Butler also provided some notes about a less "radical" and more politically feasible system reform in which the current system would not be replaced, but rather supplemented, by individual health insurance. His aim is to encourage nonemployment groups, such as unions and churches, to purchase coverage for those who do not receive employment-based coverage. Although this is an appealing idea in some ways, it does not address many of the serious problems Dr. Butler has with the current system. Consequently, it is not dealt with in these remarks, which focus on the more fundamental (and more interesting) issue of moving toward a system based solely on individual coverage.*

than being based on the magnitude of medical expenses, it would be based solely on income. Although the proposal does not provide a formula, apparently it would be progressive, in that individuals with lower incomes would receive a tax credit that represents a larger percentage of their income.

Advantages of Individual Health Insurance Proposals

Although I was asked to critique these proposals, I want to acknowledge the innovative thinking that went into their development. The proposals directly confront a number of profound problems associated with the coupling of employment and health insurance in the United States. Although I have a number of qualms with these particular proposals, I am very sympathetic to the bigger picture: Most of the problems with our country's health insurance system stem from its linkage to employment. Therefore, more of the type of thinking that resulted in the Butler and AMA proposals would be of much benefit.

The proposals for individual health insurance have a number of key advantages over our current health care system:

- They treat those without employment-sponsored health insurance more equitably. Currently, people fortunate enough to be associated with an employer that provides subsidized health insurance receive several benefits: They can obtain group rates, they usually are not subjected to medical underwriting, and perhaps most importantly, they receive a significant tax break because the employer's contribution is not subject to taxes. All of these unfair advantages would be removed under the proposals for individual health insurance.
- They are more progressive. The current tax system favors those with higher incomes because they have higher marginal tax rates, and it favors those with richer health benefits because they receive a large subsidy. These regressive aspects of our system also would be removed with individual health insurance.
- Similarly, proposals for individual insurance target equity problems better than our current system because they favor those who are unfortunate enough to incur higher health expenditures. In essence, those in need receive the most benefit.
- They also reduce job-lock by divorcing insurance coverage and employment. In addition, a much larger proportion of the population would have a choice of health plans, rather than a single choice offered by employers.

Concerns about Individual Health Insurance Proposals

In spite of their advantages, there are some fundamental disadvantages to such proposals. Despite the dire need for health care reform in the United States, embarking on an individual health insurance system is not the way to go about it.

Four main problems exist. First, it will be even more difficult for poorer people to afford coverage than is the case now; and uninsurance rates could actually increase. Second, the system would lead to two tiers of medical care. Third, it would discourage the use of preventive care but is unlikely to lower overall health care costs. And, fourth, employers potentially could benefit at the expense of workers.

Affordability

Although the proposals state that one of their overriding goals is to improve access to care by reducing the ranks of the uninsured, this is not likely to occur. Under the proposals, insurance will still be too expensive for those of moderate means. To illustrate this point, take a look at the Butler proposal, which provides a formula. Suppose a family of four with an annual income of $30,000 were able to find health insurance at a cost of $3,000 for an annual premium. This would represent 10 percent of the family's income, and they would receive a 22 percent tax rebate. That means the actual cost would be 78 percent of $3,000, or $2,340. Few families would be able to afford such coverage.

The problem is even more acute for those with lower incomes. Suppose that same family earned $15,000. The cost of a $3,000 policy would be $2,160 (78 percent of the first $1,500, and 66 percent of the next $1,500), which would be

totally unaffordable. The AMA proposal might be more forgiving because the size of the tax rebates would be based on a family's income; but without an explicit formula, it is impossible to say.

Then there is the key question of how Medicaid would fit into the two proposals. Neither proposal mentions Medicaid, which is disturbing because it represents our country's primary means of subsidizing health insurance for the poor and near-poor. Would everyone who currently is eligible for Medicaid continue to have it? If not, I would predict a significant *increase* in uninsurance under these proposals.

The other related concern about affordability is that given the high premiums that families will face, many will choose to remain uninsured. Proponents of individual insurance might claim that this might be a fine "utility maximizing" decision, but I am skeptical on two fronts.

First, it is unclear that these families truly have (and can adequately process) all of the information necessary for making such a choice. Second, it is hardly a choice when one of the alternatives—purchasing insurance—is unaffordable. In that regard, Uwe Reinhardt (1996) has written, "To tell an uninsured single mother of several possibly sickly children that she is henceforth empowered to exercise free choice in health care with her meager budget is not necessarily a form of liberation, nor is it efficient in any meaningful sense of that term. It is rationing by income class."

■ Two-Tier Medicine

A related but sufficiently distinct issue is that individual health insurance proposals will lead to a greater degree of "two-tier" medicine than is currently the case. Simply put, the wealthy will be able to afford much better insurance than others. Not only will their policies tend to have better benefits and access to medical technologies, but they will have more freedom of choice of provider, more convenient access to better providers, and have shorter waits for appointments and services. A real concern is that plans will come in with a "low ball" bid to attract lower-income people, and then not be able to deliver the promised services (Rice, Brown, and Wyn, 1993).

Although this clearly is a problem from an equity standpoint, it also reduces the *efficiency* of the health care system. Negative externalities[2] are generated if one group is envious of another group's possessions—in this case, their better access to quality health care. (Indeed, one of the most exciting frontiers of current research in health services concerns how living in a community with more equality can, in and of itself, raise the health status of the population.[3] In this regard, Reinhardt (1992) writes:

> Suppose [that a] new, high-tech medical intervention [is available] and that more of it could be produced without causing reductions in the output of any other commodity. Suppose next, however, that the associated rearrangement of the economy has been such that only well-to-do patients will have access to the new medical procedure. On these assumptions, can we be sure that [this] would enhance overall *social welfare*? Would we not have to assume the absence of *social envy* among the poor and of guilt among the well-to-do? Are these reasonable assumptions? Or should civilized policy analysts refuse to pay heed to base human motives such as envy, prevalent though it may be in any normal society? (p. 311).

■ Discourage Service Usage but Not Reduce Costs

Although individual health insurance proposals are likely to result in a number of health plan choices, there is little doubt that proponents would like to see high-deductible plans among them. It is true that such plans will discourage service use, but I contend that this would reduce the types of services that we want to encourage—such as preventive care—but not cut the high-cost items.

When people face high deductibles, they

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[2] *An externality exists when the actions of one person or firm affect those of another. In this case, if one group of people has access to better health care services than another, it can reduce the satisfaction of the latter group, which results in an overall reduction in social welfare.*

[3] *See Vol. 76, no. 3 (1998) of* The Milbank Quarterly *for a series of articles on this topic.*

need to choose whether or not a particular service is worth the cost. Although few data exist on how different services respond to price, evidence from the RAND Health Insurance Survey indicates that when people have to pay a large share of the costs, the use of well-care services drops substantially—and much more than for other services (Newhouse et al., 1993; Rice, 1998).[4]

But perhaps the overall savings to society would make it worthwhile. This, unfortunately, is not likely to be the case. The vast majority of health care spending goes toward big-ticket items. For example, 2 percent of the U.S. population in a particular year is responsible for more than 40 percent of expenditures (Berk and Monheit, 1992). Because any hospitalization or procedure will tend to meet the annual deductible, patients will not have much financial incentive to curb medical spending with a high-deductible policy. Our emphasis on "high tech" medicine would continue.

Employers and Employees

There is one other concern with the proposals for individual health insurance. Although they call for employers to increase employees' wages by the value of the health benefits that employers previously provided to employees, one wonders whether this would occur. The current tight labor market conditions would help, but the market may be less tight in the future. In addition, one can imagine numerous ways in which employers could circumvent these rules (e.g., drop health insurance before passage of the law, underestimate the value of self-insured plans). In addition, it would seem that such a provision is unfair to those employers, particularly small ones, who were generous enough to provide health insurance benefits in the first place.

[4] *The so-called "elasticity of demand" for well care services when patients had to pay between 25 percent and 95 percent of the bill was –0.43, compared with –0.22 for all medical services.*

Conclusion

Most of the problems with the U.S. health system center on the linkage between employment and health insurance. Proposals to revamp health care policy by moving toward an individually based health insurance system are attractive because they remove this linkage. Nevertheless, the proposals put forth fail to provide a good remedy because they would likely result in an increase in the number of uninsured, would produce more of a two-tiered medical care system than we have now, and would discourage preventive care without successfully controlling overall health care costs.

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12

The Perils of Unintended Consequences

by Mary Nell Lehnhard

Introduction

Blue Cross and Blue Shield has introduced a proposal for the uninsured that relies on tax credits and deductions in both the individual and the small group market; however, I am not going to dwell on this proposal in this discussion. Instead, I would like to comment on the idea of a complete flip to the individual market, a complete delinking of the employer from the financing of health insurance.

When our Plans first looked at this idea, a number of them were very interested in it—and for a lot of the reasons that are cited in this book. These include:

- possibly a very efficient way to address the uninsured;
- reflection of a clear trend to individual empowerment with more choice and visions of people buying their health insurance on the Internet;
- perhaps less regulation because if people do not like managed care, they could purchase another product;
- elimination of what we are facing more and more, dual regulation for our insured, Employee Retirement Income Security Act (ERISA) plans that are regulated both by the state and by the federal government.

Not the smallest factor also was the thought of the brand strength; the fact that we might do very well in an individual market with our brand. We also have experience in the individual market, and increasingly, health plans do not have that experience.

We have now gone through a couple of iterations of analysis of moving to that kind of market, and we are continuing our work; I want to share some of the issues, some new, some not.

Issues of a Voluntary System

The first issue is whether a voluntary system based on individual choice will work. The first critical question is, will the number of the uninsured increase? This represents the problem of very low take-up rates in an individual market and what you need to motivate people to buy insurance.

A second question is, will the per-capita cost increase? Additionally, will the government put back in as much money as we take out of the system from existing tax subsidies and existing employer-related subsidies? What we were struck by over and over as we modeled this is the very high level of subsidy you need to get people to buy insurance individually, and even with 100 percent subsidy they do not always buy it. And that is fundamental to this debate.

Another major issue is whether it is possible to create a stable system for pooling risks in an individual market. Here, the issue is, who is going to be willing to subsidize whom? We assume that if the government goes to an individual market, employers are out of the picture in terms of financing. We will have very fundamental reforms of the individual market. Congress would not enact the idea without it. You would have guarantee issue. Any insurance company that wanted to compete in this market would have to issue coverage to anyone. It would be very visible as to who is in the market. A health plan could not hide itself. There would be mandatory pooling of risk mandated by the government, and they would put limits on how much a health plan could charge a sick group compared with a healthy group. We call those rating bands.

The critical questions are, what are the rules on pooling and rating and, even more importantly, how stable are they? And the example that I

use when I talk to members of Congress is to imagine an employer on day one. This employer has been spending, on average, $6,000 per employee. On January 1, the employees are out on their own buying individual coverage. They have been educated and they get their check. This is an employer with an average age range of 25–55. And the employer is very fair. It gives $3,000 to employees age 25; $8,000 to employees age 55. But the employees go out into a market where the premium for the 25-year-old is $1,000 and the premium for the 55-year-old is $12,000. The 25-year-old gets a $2,000 windfall, and the 55-year-old has a grossly inadequate check from the employer to purchase the coverage.

Members of Congress have started considering this problem, and their response to this is, "Well, we'll have community rating," or a single premium for everybody. And so when the employer cashes out, it is very simple. Everybody gets $6,000. You go out in the market, and there are no adjustments based on age or any other indicators.

The next scenario is one of new coalitions in Washington. One is the coalition of those 30 and younger, another of the 40- to 55-year-olds. The first year the 55-year-olds are very happy they have mandated community rating. The next year the 25-year-old groups lobby and win, and you have very broad rating bands so that the premiums reflect the real health risk of the individual—that is, lower premiums for the 25-year-olds. This would be an ongoing battle that would far surpass the intergenerational conflict we see in the Social Security program. And it would an annual battle, one that would be on the table every year as people pay their premiums.

In fact, if you look back at the history of Blue Cross and Blue Shield, this has been our major issue at every turning point. We used to community rate. But large employers said, "Don't ask us to subsidize anybody but the large group market." Small groups said, "Don't ask us to subsidize the individual market." So, we broke up that cross subsidy. Then healthy small groups said, "Don't ask us to subsidize sick small groups." So, you started seeing very large rate variations in the market among small groups.

And then the states came back in the small group market, and said, "Enough." In almost every state, the legislators told insurers to pool all of their small group business. For Blue Cross and Blue Shield, or any business in the small group market, the states put all of companies' small groups in one pool, and they limited how much companies can charge the sickest groups versus the healthiest groups. We actually do not have any issues of the dry cleaners with six sick employees any more because they are in a pool with tens of thousands of small employers.

In a sense, members of Congress who support an individual market are saying, "Let's go back to the beginning of Blue Cross and pool everybody." But we know from history that these cross-subsidized pools are inherently unstable, and groups very quickly want to get out of them based on their own health status today. They do not really think about the future.

The bottom line is that all this made our plans realize that the amount of cross subsidy going on in current employer groups is way underestimated. It is enormous, and it is accepted politically by individuals. It is just a fact of working for someone because it is part of the whole compensation package. Before we get rid of this benefit cross subsidization, one of the most critical things we have to think of is whether we can replicate that cross subsidy and, even if we can, on January 1, 2001, is it going to be stable? Can it be sustained?

■ Regulatory and Reserve Issues

We have thought about a couple of other issues as we have worked through this. We are not sure it will end up with less regulation. Those who are familiar with the individual market know that it is very high risk and very hard to manage. Companies come and go. Health plans leave people without coverage. It may well be that the resources devoted to regulating the health insurance industry would grow, in fact, grow geometrically. People would be on their own, and they would be very vulnerable. Again, we cannot underestimate the major contribution employers have made, in this case, in providing oversight for a huge share of the market in the absence of the state insurance commissioners regulating it.

A final issue for consideration is the issue of reserves and capitalization. The individual market is very high risk, and we have to maintain reserves. You have to keep your reserves at differ-

ent levels based on the risk of the product. The individual market is the highest-risk product, and you need reserves of about two to three months for every person you enroll. If you go out of business, you need to be able to clean up the claims that are left outstanding.

We estimate that, very roughly, the additional capital going into this new individual market initially might be close to $30 billion. That is a huge accumulation of cash by companies that would be in this business.

■ Conclusion

In terms of alternative delivery systems and alternative pooling mechanisms—such as association health plans and multiemployer welfare associations (MEWAs)—there is one thing I have learned in my years in this business: Beware of unintended consequences. As we look at alternative pooling mechanisms, for example for small employers, I would urge us to be aware that the states have done a very good job of forcing insurance companies to pool all their small group risks—not only pool them but say, "You put them in one pool and you can't charge more than twice as much for a sick group as a healthy group."

Before we go about letting groups jump out of that big state-regulated pool into essentially unregulated federal products we have to think about what that does to the groups left in the state pool. Does the risk selection in the regulated pool get worse and worse to the point that some companies say, "We don't want to manage what's left because the risk selection is so poor." This business is fraught with unintended consequences, whether they are big scale or little scale changes.

13

One Company's Experience With Regulation

by Carl Scott

■ Introduction

The intellectual capacity that has been brought to bear in this forum to try to sort out all of these issues is impressive. The perspective I am bringing is much different. My discussion centers on one company and our reaction for the past eight years to unprecedented and increased regulation of the individual major medical market place and the small group market place. This will give you a flavor of what could happen if you decided to unwind the employment-based coverage.

We think we need to retain, sustain, and enhance the opportunities and the abilities to purchase coverage and to acquire the coverage through the employment base and then create an opportunity for those that do not get their insurance that way to purchase it equitably in another fashion.

■ The Disconnect Between Consumers and Providers

Mutual of Omaha is still, I believe, the largest individual commercial carrier in the individual major medical market place. I cannot be sure it is the largest because this is a changing dynamic market with carriers coming and carriers going and health maintenance organizations (HMOs) beginning to develop the individual market place, although they are very reluctant to do so. HMOs have no great desire to solicit individual policies when they understand that underwriting is real, that anti-selection takes place, and they do not have the infrastructure to manage individual risk. They are not anxious to absorb the individual market place.

I would also point out that I know the exact point in time when we began to have problems with this issue of cost and access. It happened at 3 p.m. on Aug. 31, 1972. How in the world can I be that precise? Because it was on that day that my wife and I took our third child to the pediatrician for a normal checkup. With our first two children, every time we finished with the doctor, the doctor would hand us a slip. On that slip he would write down how much he charged, and we would take it out to the front and either pay it in cash or we would say that we were going to send in an insurance claim.

On that day, the doctor did not do that. He said, "Just go the front window and my business people will take care of it." So, we went to the front window and what had been on previous visits an $8 charge now was $15. So, we walked back to the doctor and said, "There must be a mistake." He said, "Oh, there is." He adjusted it back to $8. But the bottom line is: That happened universally across the entire country. There was a disconnect between the consumer of health services and the provider of health services. And all the other discussion gets to be chaff in the wind because we put third parties between the consumer and the customer.

■ The Individual Market Place

We sell individual major medical insurance, and do you know what the consumer chooses to do? We offer deductibles all the way down to $500. First, 85 percent of the consumers who purchase from us choose deductibles of $2,500 and higher because they can afford it. Second, they would prefer to assume that first-dollar risk and have a chat with their doctor and their hospital about what they are actually going to charge them for the services rendered, and they work their own deal. If you

watch, those consumers are making good use of the individual clout dealing with the doctors.

If employment-based coverage is minimized or eliminated, the individual market place will deal with many difficult challenges. I will just add to a point that Mary Nell Lehnhard made without going in any more detail.[1] Currently, there is not sufficient capacity in the individual market place to absorb all the people who would fall out of a group environment. It just is not there. Under the current rules, reserve requirements, state insurance regulations, and all the things that have to be done to manage the fairness and equity of the individual pool, it is not possible.

We have discussed guarantee issue and community rating and what works and what does not work. I will tell you about what has happened with our company. In the last eight years, we have withdrawn the sale of individual major medical policies from eight states. The reason is not because we wanted to get out of the business—because we are in the business to sell insurance. The reason is that we could no longer manage the risk. It is an impossible situation when regulators and legislators define the products, define how they will be rated and priced, and the third party, the insurance company, is supposed to assume and manage the risk in that environment. In those states, we have withdrawn.

One reason is because we have a responsibility to those we insure. Some of the largest group pools in the United States today are individual insureds, hundreds of thousands in a pool that are managed like a group. Once they are in the pool, they cannot be singled out for rate increases. They cannot be treated differently, and their rates are managed as a pool. That exists today. I have heard discussions of use church groups or affinity groups or this purchasing pool and that purchasing pool. Those things already exist.

We have a number of very large endorsed associations. You know what the biggest problem is? In a voluntary setting, on average, less than 12 percent of the people participate in the insurance program. You cannot guarantee issue and manage anti-selection with 12 percent participation in a voluntary setting. That is the leverage the employer group brings to us. The employer says, "You work here, you have your insurance here, and there are a pretty stringent set of participation requirements."

If you would give me an association group and say, "I will guarantee that 85 percent plus of those people would enroll," I will modify all kinds of insurance underwriting practices and will do it now without any regulation or any change in federal requirements.

One of the things that carries on from that 1972 example is the difference in how we buy cars. You can walk into the dealership, look around, and say, "I like the red one. I want chrome wheels, big wide tires. I want a stereo system with a 12-disc changer and what else? Oh, air conditioning. I want leather seats. I want the whole thing. And I'd like to have it delivered Friday." You shake hands with the dealer and you walk out, and on Friday, the car is delivered to your house. You love it. I mean your family loves it and your neighbors think it is wonderful. You're driving around in this car. It's great.

Three weeks later you get a bill from the engine manufacturer. You bought a V-8. You could have had a V-6, but you bought the V-8 because you thought it would be cool. It was $8,000. A couple of weeks later, you get the bill for the tires. Those mag wheels cost another $5,000. A few weeks later, you get a bill from Body by Fisher for $15,000. GM sold Delphi, so you have things like alternators and regulators, spark plugs and all that miscellaneous stuff that goes in. You got your bill from them. It was another $22,000.

If anybody is keeping track, you got a 1999 Chevrolet, but you paid $50,000 for it, and you did not have a clue what you paid for it until three months later. That is how we buy medical care. We have to do something different about how we consume, both as individuals and as groups.

Businesses have attempted to become an intermediary in that, and that is where managed care came from. They stepped up and said, "Somebody has got to go out and negotiate these deals and see if we can get a better price." Well, there has to be a way to reintroduce competition into this environment. And the competition says that doctors and hospitals have to disclose what their prices are in advance, how they relate to some kind of a national index so people can make some decisions. I

[1] *See Mary Nell Lehnhard, "The Perils of Unintended Consequences," in this volume.*

recognize that in the emergency setting, that may not be easy. But most medical care is not an emergency, and, in fact, doctors and hospitals can be chosen if people become consumers well in advance of an event.

Elimination of Mandates

If we are, in fact, going to expand the individual market place and if it is going to be a viable market place, there are some things we can do. One is to eliminate the 900-plus mandates that the state insurance departments have applied to the individual market. And as mentioned, with the Employee Retirement Income Security Act of of 1974 (ERISA), all of those mandates are eliminated from virtually all self-insured business so that 65 percent to 70 percent of the people who are insured in large group plans and the self-insured do not deal with the mandates.

The only piece of the market left that does deal with mandates is the individual market place, and, on average, fortunately, not all mandates are in every state. The hair transplant one, that is one state. One state tried to pass a mandate that said your pets had to be covered just like dependents. We did not have to do that one. It got to the senate before it was defeated, but it was a close vote.

Eliminate the mandates and you reduce the price of insurance 16 percent to 20 percent. I am not talking about cutting out fundamental benefits; I am talking about eliminating what most consumers think are nonessential benefits and, if you gave them the option, they would not buy them.

You also need to reintroduce competition. How do you do that? One of the ways would be to say, “Okay, the government in the Medicare Program has defined Resource Based Relative Value Scale (RBRVS) for physicians and Diagnostic Related Group (DRG) for hospitals as a benchmark on what medical costs will be reimbursed. So, let us just say that is our benchmark and, as a designer of insurance policies, we will offer a policy that will pay that benchmark. Or, if you as a consumer want to pay the doctor or hospital more or less than that, you can buy an index higher, index lower. It would be your choice.

Conclusion

Recognize that we already have some of the largest insurance pools in the country, and we know how to manage them. We understand affinity groups. We would definitely agree that if we can have some tax equity in the individual market place, there would be people who would be inclined to purchase who are not so inclined to purchase today. But the real issue is reducing the cost of health care. If we addressed the market issue and reimbursed medical expenses at the government reimbursement rate, we believe we can reduce the cost of an individual major medical policy 30–40 percent today without new regulation, legislation, or government intervention.

14

Transferring the Tax Preference to Employees: More Regulation

by Dwight K. Bartlett, III

Introduction

In thinking about this discussion, it occurred to me that there were four groups, as shown in chart 14.1, who would be interested in this question: What would be the result of transferring the tax preference from the employer to the employees? After I did this chart, it occurred to me that there is even a fifth group—the health care provider group. But I guess, in a sense, that group is simply the victims or the group that is simply impacted by the decisions made.

Chart 14.1
Groups at Interest

- Employers
- Employees
- Insurers
- Regulators

Source: Dwight K. Bartlett, III.

The first two groups have been more than adequately covered by people who know a lot more about the subject than I do, but I simply want to state my assumptions for my later comments.

In many instances, the employer will drop its group health insurance and will increase cash compensation to employees as an offset for that (chart 14.2). Employers will generally believe that it is in their business interest to have healthy employees with health insurance. So, they will tend to support programs to increase accessibility and affordability of health insurance for their employees.

Chart 14.2
Employer Response to Loss of Tax Deduction

- Drop group health insurance.
- Increase cash compensation to employees.
- Support programs to increase accessibility/affordability.

Source: Dwight K. Bartlett, III.

As for employees, I assume that many will buy health insurance, particularly the older and the sicker (chart 14.3). Many, particularly the younger, healthier, and the lower-income individuals, will, however, opt out of health insurance, and the result will be a substantial degree of anti-selection, with the resulting higher premiums coming from that anti-selection. In other words, I assume that many employees will be thrown into the individual health insurance market who are not now in the individual health insurance market. What are the consequences of that?

Chart 14.3
Employee Response to Receiving Tax Deduction

- Many will buy health insurance, particularly older and sicker.
- Many, particularly younger, healthier, and lower income will opt out.
- Result will be anti-selection/higher premiums.

Source: Dwight K. Bartlett, III.

Inefficiencies of the Individual Health Insurance Market

One of the problems arises from the inefficiencies of the individual health insurance market. Table 14.1, from the 1998 *Statistical Abstract of the United States*, is somewhat deficient because I do not

Table 14.1
1995 Claims and Premiums
(Billions)

	Claims	Premiums	Ratio
Individual Coverages	12.0	17.5	68.6%
Group Coverages	98.1	116.4	84.3

Source: U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States* (Washington, DC: U.S. Government Printing Office, 1998).

believe it includes claims and premiums from managed care plans, for example. I think the data are from traditional health insurance plans. But, nevertheless, I think it indicates in a general way the inefficiencies of the individual coverage market. In a sense, you can say that the individual market is twice as inefficient as the group market in that the difference between 100 percent and the claim ratio, being what is required by the insured to cover the insurer's expenses and profit margins, is twice as large for the individual coverage market as it is for the group coverage market.

If this tax preference is transferred from employers to employees, health insurers, particularly those in the individual health insurance market, will attempt to respond appropriately to deal particularly with the inefficiency of the individual health insurance market. Most of that inefficiency arises as a result, first of all, of commissions paid to the sales people for the individual policies but also as a result of the underwriting costs associated in the risk-selection process for individual insurance.

Individual policy health insurers will try to figure out more efficient ways of distributing the product (chart 14.4). They will look more and more to direct response type of distribution, which does not involve commissioned sales people. They will look to work place-based distribution systems where employees can buy health insurance in a plan not sponsored by the employer but one in which the employer will provide, for example, payroll deduction for the individual health insurance premium.

The individual policy health insurers will attempt to adopt more simplified underwriting and rating procedures. They will try to avoid doing very

Chart 14.4
Health Insurers' Response to Deduction Transfer

- Direct response distribution.
- Work place-based distribution.
- Simplified underwriting and rating.
- Lower commission levels.

Source: Dwight K. Bartlett, III.

expensive medical examinations or blood tests and rely on more generalized statements by the applicants as to their health condition. They also will adopt broader band rating for the premium rates for their policies, and they will adopt lower commission scales, presumably because the market will be greatly enlarged and it will be easier for sales people to make sales. That will be a justification for paying them less per sale for making an easier sale.

Response from the Regulatory Community

As a former regulator, I am particularly interested in the likely response of the regulatory community in terms of what changes would be forthcoming. Regulators will try very hard to improve the affordability and accessibility of health insurance in the individual health insurance market, and they will likely do a number of things to improve affordability and accessibility (chart 14.5). One would be to require standardized benefit packages to deal with the question of anti-selection involved in a multiplicity of available plans but also to help consumers make appropriate choices by clarifying the issue of what is available.

Chart 14.5
Regulators' Response to Deduction Transfer

- Standardized benefit packages.
- Higher minimum loss ratio standards.
- Community rating.
- Guaranteed issue.
- Risk-sharing mechanisms.
- Federal pre-emption.

Source: Dwight K. Bartlett, III.

For example, we know that the federal government has done this for medigap policies, by limiting the available selection to 10 standardized plans.

Regulators will impose higher minimum loss ratio standards. Many states now have minimum target loss ratios for individual health insurance policies, usually in the range of 65 percent to 75 percent. I think they will be inclined to push those minimum acceptable standards upward toward 75 percent or 80 percent.

Many states will attempt to impose community rating and guaranteed issue requirements. Frankly, I am not a fan of these kinds of requirements. I believe that where they already have been adopted in a number of states for the individual and small health insurance market, they have not worked well. I look at the examples of the experience in Kentucky, New Jersey, and New York, where the markets have been in disarray because the states have imposed community rating and guaranteed issue standards. The Health Insurance Association of America published a study recently that claimed to show that those states that had been most aggressive in adopting community rating and guaranteed issue requirements also had the largest increase in the percentage of the uninsured population.

States will also attempt to develop additional risk-sharing mechanisms, such as pools, for people who would otherwise be uninsurable, where the extra cost because of their health condition will be spread across the health insurance industry.

Conclusion

Lastly, I believe there will be a definite attempt to enlarge the federal pre-emption of health insurance regulation. With a multiplicity of inconsistent rules and requirements in the 50 states and the District of Columbia, the only way to produce an orderly market is for the federal government to pre-empt all of that and set uniform national standards. From my own regulatory experiences, that is the likely reaction of regulators to the transfer of this tax preference from employers to employees.

I think voluntary markets will tolerate a degree of community rating. I think a requirement of absolute community rating where everybody pays exactly the same rate regardless of their age or gender or health condition or whatever, normally reflected in risk classification, won't be tolerated in a voluntary market. But it will tolerate a degree of community rating. I think the problem for regulators is to try to find out what that degree is. How far can you go in imposing community rating without destroying the market? And I don't know what the answer is, but I think there is an answer somewhere.

15

Unlinking Health Insurance from Employment,
Disrupting the Social Contract: Chaos for Employers and Employees?

by Kenneth R. Jacobsen

■ Introduction

Let's first acknowledge that there are small and large employers, public- and private-sector employers, those with bargaining units and those that are fully nonunion. There are young firms, i.e., those that have been around for two years, and old established firms that have been in existence for 200 years. My comments cannot possibly validate the perspective of each and every employer in all of those categories.

Having spent the last 20 years working with large employers, I believe I have a pretty good understanding of what most of them would say from a practical standpoint on this topic, and will discuss unlinking health insurance from employment from that vantage point. I cannot think of an employer who would not love to have the whole issue of sponsoring health benefits go away. If fairy tales could come true, they would immediately say "take us out of this game." But as that is not a likely outcome, it is not the perspective I am offering.

■ Benefits as Part of a Social Contract

About 139 million people, or 61 percent of the population, are covered by employment-based health plans (chart 15.1). The uninsured number in chart 15.2, from the Lewin Group, is around 43 million, according to the U.S. Census Bureau. There's a serious inequality here. Employers who provide health insurance are clearly cost-shifted

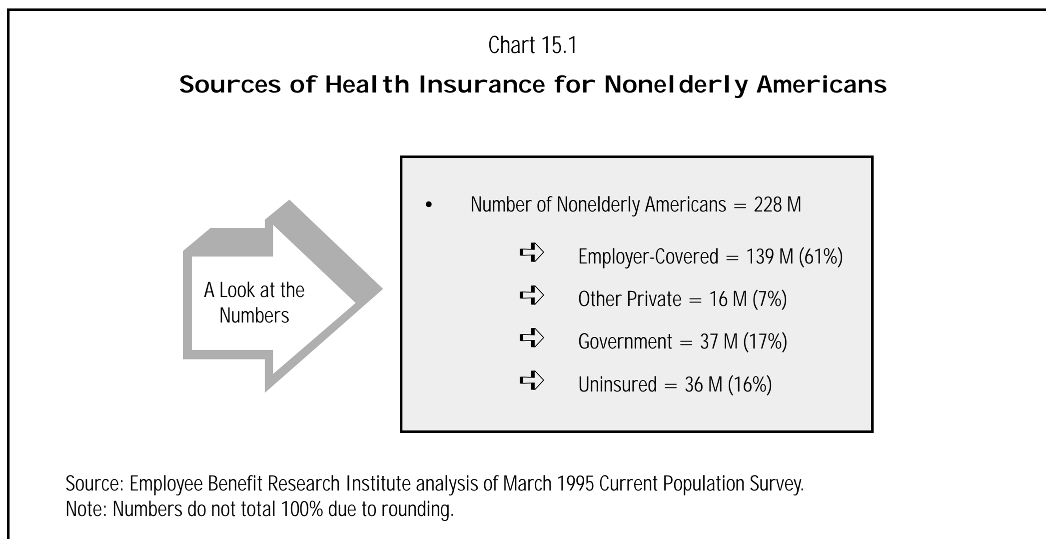
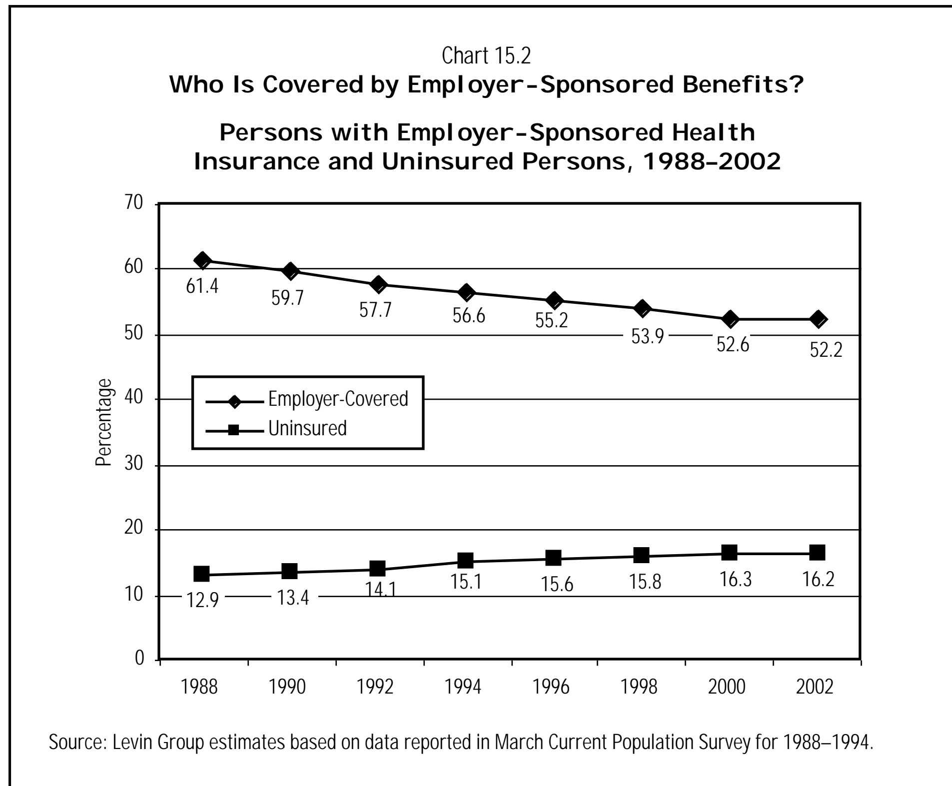


Chart 15.1

Sources of Health Insurance for Nonelderly Americans

Source: Employee Benefit Research Institute analysis of March 1995 Current Population Survey.
Note: Numbers do not total 100% due to rounding.



against by indirectly paying for workers who are not provided employer-based health plans. Seventy-eight percent of health care costs for the under 65 population (non-Medicare/Medicaid) are picked up by insured and self-insured plans, according to Health Insurance Association of America estimates.

This gets to the crux of what could really be a central issue, which is either to require all employers to cover health insurance or develop a universal, single payer government plan.

Social Contract

For employers, there clearly is an advantage in recruiting and retaining employees by providing a solid fringe benefit plan, particularly health insurance (chart 15.3). This remains consistent year after year, with occasional bumps such as when employers are pushed by the economy to tighten their belts as in the early 1990s, and paternalism became secondary to fixing the bottom line. But the pendulum has swung back, and a renewed social contract exists through the provision of employee benefits.

In addition to the financial relief that benefits offer, healthy employees are very important to any business. Although it is arguable whether employers really want to be in the business of providing health insurance, never mind managing their employees' health, emerging trends include broader integrated strategies that address health benefits, disability, absenteeism, and productivity. A well-managed, fully integrated health insurance plan can help an employer keep people healthy on the job, thus improving overall productivity.

Other discussions in this book talk about tax benefits to employers, which are an incentive for the provision of these plans, so I will not address that topic here.

Increasing Costs, Administrative Burdens

Administratively, it is expensive to maintain benefits. Health care costs increase every year and, in some underwriting cycles, quite dramatically, sharply impacting corporate budgets. Interestingly enough, despite certain years of high medical inflation, the relative cost of fringe benefits to the employer has held steady for almost 20 years. In 1980, 17 percent of compensation on average went toward fringe benefits, and in 1997, it was the

Chart 15.3
Employer Perspective: Offering Employer-Sponsored Health Benefits

PROS	CONS
• Recruiting/retention	• Expensive to maintain
• Paternalism	• Increasing health care costs
• Healthy employees ➪ productive employees	• Managed care controversy
• Tax benefits	• Compliance and administrative burdens
	• Accommodate needs of a diverse work force

Source: Kenneth R. Jacobsen.

same number, 17 percent.

Other issues include the controversy over managed care, which disrupts employer/employee relations because the system produces many complaints. Constantly remaining compliant with legislative changes also contributes to heavy administrative loads. Demographic changes provide a constant challenge to employers. Employers know that the days when Wally and the Beaver were kids, when one-size-fits-all benefit strategies served the work force, are gone. Employers have to offer many different options to meet the needs of today's diverse work force.

Charts 15.4 and 15.5 give a quick picture of the market system, for better or for worse, as it currently exists. Employers purchase group plans from a defined, mature market place. Employees choose a plan the employer offers, and in the majority of instances, pick providers from a defined

Chart 15.4
Offering Employer-Sponsored Benefits: Snapshot of the Market

- Employers purchase group plans from insurers/HMOs
- Employees select providers based upon employer plan
- Providers serve patient population, steered by plans

Source: Kenneth R. Jacobsen.

Chart 15.5
Without Employer-Sponsored Benefits: Possible Snapshot of the Market

- Consumers purchase plans directly: (Equipped to navigate market?)
- Consumers select providers: Impact upon selection/delivery system
- Who disciplines insurance industry and delivery system (Consumers, government)?

Source: Kenneth R. Jacobsen.

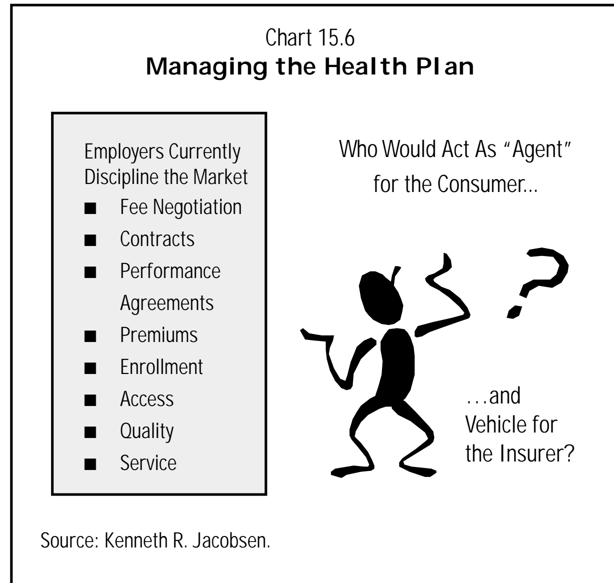
panel, which incidentally works to the advantage of the delivery system as well because it provides a stable and predictable mechanism for the flow of paying patients. Essentially, in the current environment, employees rely on their employers to manage the purchasing and administration of health coverage for them.

■ Replacing Employers as Agents

I believe that if we were to discard the existing system we would wreak new kinds of havoc. As other contributors to this book have pointed out, employers act as agents for 61 percent of the under 65 population. They navigate the market on behalf of people who consume health insurance—the employees. Employers negotiate fees, volume purchase, deploy middlemen, brokers and consultants, to extract a fair price. Consumers are generally not capable of that on their own. Additionally, employers scrutinize contracts to check fine print, identify loopholes, etc. Again, anybody who believes most consumers will be capable of this is not being realistic. We can load all the information we want onto the Internet, but the average consumer won't have the knowledge and sophistication to sort through something as complex as health insurance purchasing, never mind performance management, quality and service issues, renewals, etc.

And, how would consumers and the industry manage premium remittance? With the current employment-based system, premiums are paid to the insurance company via a lump sum, automatically deducted from payroll. To devise a system to collect premiums from individuals and reliably get them to the insurance carrier would require the creation of new, complex infrastructure. The administrative challenges and capital outlay would be enormous. Employers also monitor access to the health system on employees' behalf. They scrutinize the plans for geographic matches, making sure that the plan has doctors and facilities where people live and/or work.

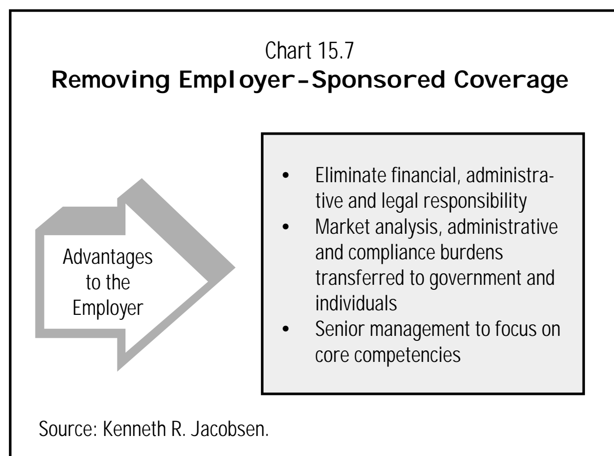
Note the employer acts not only as the agent for the consumer in this case, but in effect as a vehicle for the insurer (chart 15.6). The insurance industry would not want to convert to a fully individual market place, selling to and enrolling 161 million people, conducting risk assessments, etc. It is much more efficient to pick up blocks of 200 or 20,000 people at a time, as the market works currently. Further, employers would face work force disruption if employees were suddenly faced with shopping for health insurance, plus a potential loss of productivity resulting from sickness without coverage. There would be other inevitable occurrences such as the time consumed by individuals to work through coverage, payment issues and so on, administrative issues that are typically handled by the benefits department.



Source: Kenneth R. Jacobsen.

■ Advantages

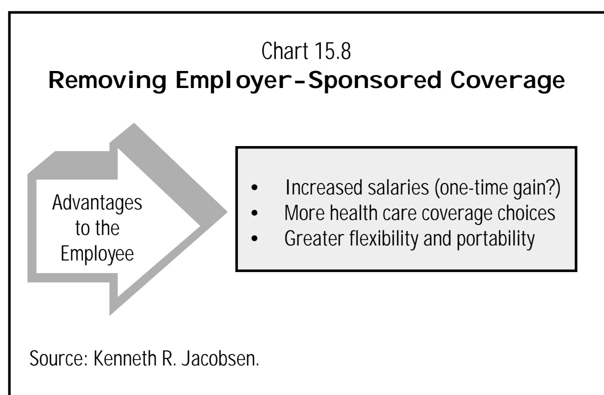
There are obviously advantages to removing the burden of employment-based coverage from employers (chart 15.7). As discussed, it would eliminate financial, administrative, and legal responsibilities, market analyses, compliance burdens…..



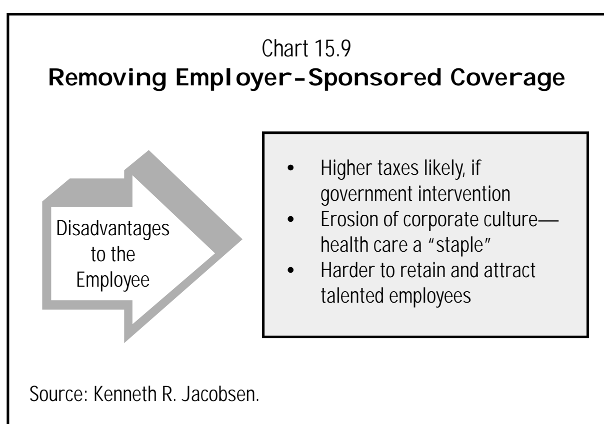
Source: Kenneth R. Jacobsen.

activities that distract senior management from putting all their energies into their core businesses. If employers could wave a magic wand, yes they would love to walk away from all this.

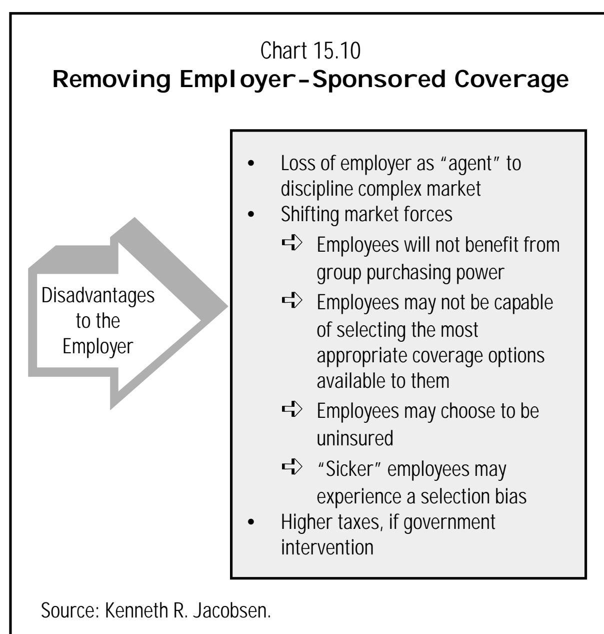
What are the advantages to employees? One might anticipate higher compensation as dollars are shifted to pay instead of benefits, but the likelihood is it would be a one-time gain (chart 15.8). And whether that increase would end up in their pockets, or paid in taxes or insurance premiums is not answered in this discussion. One positive result is that employees would have more health care choices than the two or three plans that their employers might offer today, and health care coverage would have greater flexibility and portability, eliminating the job lock problem.



But there are disadvantages for employers, too (chart 15.9). Higher taxes are likely, if not a certainty, if the government oversees the game. There would be some erosion of the corporate culture, at least initially. Health care is a linchpin in the employer/employee relationship. It would be more difficult to retain and attract talented employees because, clearly, corporations use their benefit programs to distinguish themselves among their competitors in the labor market.



Employees also would lose their agent, who disciplines a very complex marketplace on their behalf. They would lose the leverage of group purchasing power, thus pay higher rates. Employees may not be astute enough to select the most appropriate coverage options available to them. They may choose to go uninsured, which other chapters on this topic have addressed. And the sicker employees might get selected against as a result of individual underwriting. And it is not likely we will escape higher taxes if the system is revamped with the government's involvement—even if their intent is to guide us to an individual market versus a single payer system.



■ Conclusion

If I am a large employer contemplating the disruption likely to occur as my employees are transitioned into a vastly different system, and they have to adjust to the market impact, or tax implications, or navigate the Internet every day, just for health care, I need to brace my company for a significant distraction to my employees. Appar-

ently there is no telling how long this will take. What I can glean is that my business is going to be materially affected during this transition, with no clearly stated alternate solution. Without a well-formulated plan at the policy level that spells out how the transition will actually work, my answer to this proposition is "No thanks, I will stick with the devil I know."

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16

A Small Business Perspective on the Employment-Based System

by Victoria Caldeira

Introduction

The National Federation of Independent Business (NFIB) is the largest advocacy organization for small businesses. We have 600,000 members in all 50 states. Currently, 44 percent of our members actually provide health care.

Health Care Costs

We poll our members every four years on what constitutes their biggest problems, and every year for the past 12 years, the cost of health care has ranked as the No. 1 problem for small business owners. That is ahead of some other very significant problems, such as tax reform and regulatory reform, which are very important to our membership but not nearly as significant as health care. We believe the reason for this is that our members really want to provide health care in the current market place, but at present, they cannot due to its high cost.

At NFIB, we take public policy positions only on those issues for which we have polled our membership. Two ballots are particularly relevant to this discussion. The first is that 89 percent of NFIB small business owners believe individuals without employment-based health insurance should be able to deduct the full cost of their health insurance premiums. We just questioned them in January on this issue, but previous ballots in 1993 and 1990 were consistent in wanting this deduction.

Another ballot that reflects their concern is that 62 percent of NFIB's members believe the business deduction for the purchase of health insurance should not be eliminated in any move to a tax-credit system that is more individually based.

The Desire for More Choices

From these ballots, as well as discussions with our members, we at NFIB conclude that our members desperately want more choices in the market place and better value for their dollars when it comes to purchasing health care. But in spite of their need for more choices, small business owners currently are not willing to give up the benefits of our current system that they enjoy today. So, reforms that complement our current system are viewed favorably by our members. At the same time, proposals that are viewed to remove or radically alter benefits, such as tax benefits or other benefits from the current system, are viewed with skepticism.

Of all the tax credit proposals NFIB has seen to date, I believe the proposal that would be most attractive to small business owners is one written by the National Association of Health Underwriters. This tax-credit proposal has two main benefits. First, it does not seek to eliminate the employment-based system. If a small business owner provides health benefits, its employees must use their tax credits to purchase health care through the business. Second, premiums paid by employers would be treated as unearned taxable income and, therefore, not subject to FICA employment taxes or state payroll taxes. These are very unique features of the proposal. They are showing up in other proposals in Congress, and we are planning to poll our members on this issue—even though it is fairly complicated—as simply as we can to get a response from them.

The Importance of Business Size

Finally, NFIB senior researcher Denny Dennis is putting the finishing touches on a study of the relationship among wages, health insurance, pension plans, and the income of small business owners. Among other things, the study concludes that the size of the business is the most important factor to consider when determining the likelihood that a small business owner will provide health insurance. The small business owner's income is the second most important factor; however, the size of the business determines its marketing costs, its administrative costs, and cost of health care premiums.

In addition, Mr. Dennis makes the point that comparative price shopping is also very difficult for small business owners in the health care area. Often, there just are not many alternatives to evaluate.

In light of this data, we at NFIB believe that expanding the system to provide for individual health deductions or tax credits will not be very beneficial if individuals do not have other, better risk-pooling options to obtain greater purchasing power, as many contributors to this book have concluded.

Conclusion

Finally, NFIB's research indicates that in spite of the successes of our current employment-based system, there will always be a certain number of small business owners for whom the employment-based system will never work. These are businesses with low-wage employees and owners who are not making much in the way of profits. These businesses will never be able to afford health care for their employees under any conditions. For example, it came as a big surprise to me that 16.9 percent of small business owners earn less than $10,000 a year, and 15 percent of self-employed heads of households make zero dollars in income in any given month. So, therefore, we believe that options for these individuals away from the employment-based system have to be developed.

We at NFIB believe that greater access to health care will be achieved by giving small businesses more choices and lowering the cost of health care per employee. To this end, we have three legislative priorities. First, we oppose all health care mandates. Second, we support the ability of small businesses to purchase health care through interstate association health plans. And third, we support expanding the deductibility of health insurance for both the self-employed and those without employer-subsidized insurance.

17

How Will Employers Respond If Health Benefits Tax Preferences Are Removed?

by Raymond B. Werntz, Jr.

Introduction

This is a difficult question for an employer to answer even though I was one for over 30 years. Employers are not monolithic (see Jacobsen[1]) and all are not equally sensitive to costs associated with tax preferences. More importantly, there is a fundamental difference between paying for "insurance" and purchasing health services for our employees and their families. A more pertinent question might be "does it matter if the link between employment and health coverage is broken—to employers, employees and their families, or to the health care system itself ?" That second question may the better one to answer.

Other Problems Facing Employers

Elimination of tax preferences is not the only threat to continued benefit sponsorship by employers.

The widely reported backlash against managed care threatens the future viability of the flexibility in plan design and administration granted under the Employee Retirement Income and Security Act of 1974 (ERISA). A good case can be made that large employers such as those in the Employee Benefit Research Institute have had a very positive influence on quality, efficiency, and organization of health care that "spill over" into the community.

We are also entering another period of high (medical cost) inflation that some believe will be significant and of long duration. If this results in more cost shifting to employees, because some employers can't—or won't—absorb these new costs, some of the other problems mentioned in this book will be further exacerbated.

Finally, there is the matter of numerous legislative and regulatory proposals to protect consumers from what some believe is managed care's "dark side." These proposals are aimed mainly at ERISA plans—and by implication—their employer sponsors.

Stepping back from these proposals and observing them as a mosaic, they attempt to accomplish one or more of five types of results:

1. Restore benefits curtailed by managed care, i.e., hospital care for mastectomies.
2. Codify the process for determining benefits and administrative rules.
3. Require more extensive disclosure of such processes.
4. Accelerate such processes and add legal remedies to enforce them, such as injunctive relief.
5. Neutralize the ERISA shield that insulates health plans from state tort liability.

In the aggregate if all these proposals were enacted, they would roll back most, if not all, of the most widely used cost and quality management tools used by employers today.

Managed Care

When I began my career in human resources three decades ago, employers bought health insurance for their employees. Using volume leverage and tax preferences, employers could offer their employees efficient, low-cost protection against the high cost of

[1] *Kenneth R. Jacobsen, "Unlinking Health Unsurance from Employment, Disrupting the Social Contract: Chaos for Employers" in this volume.*

health care such employees arranged for on their own. Insurance company services were invoked after the care was provided. Disagreements in those days were over dollars, not over whether care was to be provided.

Managed care operates under a different set of rules—it now acts before the fact. Proponents contend that managed care's virtue lies in its ability to sort appropriate from inappropriate care. Others claim that managed care denies care merely to save money. In either case, insurance—or managed care—companies are now invoked before the fact, and have profoundly influenced the organization and delivery of health care for everyone in this country, not just those covered by employer plans.

A few days ago, I found an article about Allied Signal's ground-breaking arrangement with Cigna that signaled the beginning of business's love affair with managed care. The article was written in 1990—that's less than 10 years ago! Most would agree I believe that our first priority was cost back then. However, it's been my experience that today leading edge employers are increasingly more preoccupied with care quality. In any event, because managed care is still an adolescent, I suggest that we not be too eager to dismantle and replace it because it has some rough edges.

Back to the questions I posed at the beginning of my remarks: How will employers react if tax preferences are taken away, and does it matter?

Five or more years ago, I might have said that employers would likely head for the hills—especially when health care inflation was such a problem. Today we know much more about the importance of care quality and the relationship between employee health and productivity than we did only a few years ago. As a result, I'm not so sure that employers would cut and run today.

In my opinion, the answer to both of my questions depends on how employers define value. Are we only concerned with the cost of services we purchase for our employees and their families relative to other costs, or does employee and family health confer an economic benefit on our shareholders equal to or greater than its cost?

I wouldn't say that anyone is certain that there's a better metric than cost today. However, there are some good folks at the Washington Business Group On Health (WBGH) who are working very hard to find such a metric if one exists. I commend to you the recently released report on the WBGH Health and Productivity Management Initiative.

■ Conclusion

I don't claim to know with certainty if the American health care system would be better or worse off if health benefits were decoupled from employment. However, as a human resources professional, I am convinced that employee innovation and commitment are essential to profits and the market values of our businesses. The value of health, therefore, seems to depend on its importance to employee performance that drives shareholder value and the economic vitality of our communities.

We all have a lot at stake if there is more to health care than cost, and business has a powerful incentive to embrace the WBGH initiative and others like it. I, for one, think that a health care system built on value purchasing makes more sense to me and my family than one dedicated exclusively to cost containment.

18

Subsidies and Market Reform

by Deborah J. Chollet

Introduction

One of the things that we have learned—both from research and from the Employee Benefit Research Institute policy forum—is that two kinds of people need subsidies in any health insurance market. Whether it is a group market or an individual market, people with low incomes and people who are sick need subsidies. The employment-based system provides those subsidies, more or less, to those who are sick. Certainly under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we have better protection in that market for people who are sick, although it is not perfect.

The Problem of the Working Poor

The problem of the uninsured in this country is a problem of the working poor and near poor. People in large firms who are uninsured typically are low-wage workers, just as the uninsured in small firms typically are low-wage workers.

The important question is whether we can re-allocate existing subsidies to insured workers or whether we need new money to extend insurance to uninsured workers and dependents. It is fairly clear that existing subsidies are not allocated optimally, but it is not clear that they can be re-allocated optimally. As William Custer has suggested,[1] we may already have achieved second-best in the current system, and we may need to set about creating something new.

As employer coverage has ebbed, public coverage has expanded. Whether this is crowd out or whether it is coincidence, we do have broader public coverage in this country than ever before under Medicaid and under the State Children's Health Insurance Program (S-CHIP) programs, presuming we ever get the participation in CHIP for which we had hoped.

At the same time, we have welfare reform, which has thrown large numbers of very low-wage workers into employment situations where they do not have benefits. They go to work places that do not offer benefits, or they are in employment categories in firms that offer benefits, but they are ineligible. There are all sorts of ways that low-wage workers can miss having employment-based benefits and, by and large, they do not end up in employment-based plans.

But the cup is not entirely empty. Large numbers of low-wage workers do get benefits through employer plans, and that is what makes this subsidy issue so difficult when we consider running subsidies through employment-based plans. Still, low-wage workers miss out more often than higher-wage workers.

The Widening Distribution of Income

Throwing low-wage workers into the work force via welfare reform, even though those workers usually remain eligible for Medicaid, has been a problem because the workers are unaware that they remain eligible for Medicaid. Medicaid coverage has dropped immensely, and, therefore, the number of uninsured continues to increase. Workers who believe themselves to be uninsured act uninsured in their use of health care.

The entry into the work force of large numbers of low-wage uninsured workers exacerbates a widening distribution of income in this country that is a big problem. It is a problem certainly for workers unable to find or afford health

[1] *See William Custer, "The Tax Preference for Employment-Based Health Insurance Coverage" in this volume.*

insurance, but it is also a social problem. It has recently become a little less of an issue because, economically, all ships are rising. But when all ships are no longer rising, the widening distribution of personal income may well re-emerge as a major a social policy issue.

I believe it is a legitimate issue when we consider what to do about the uninsured and how to re-allocate subsidies for people to buy health insurance for a large and growing number of workers the employment-based system of coverage is not a work incentive. For most of the people we say we are worried about—those who are currently uninsured—the offer of a health insurance benefit from an employer is not the reason that they are working: the jobs open to them do not offer a health insurance benefit. If health insurance does not offer a work incentive, and the absence of it widens the income disparity, we have to ask whether the work place is the right place to locate the nation's principal system of health coverage.

■ Individual Insurance Reform

Refundable tax credits have a real elegance, and they can be structured to minimize the disruption of the employer system. We have heard several kinds of proposals that would in fact minimize this disruption and offer employees choice. But they rely on the individual market, and we have spent a lot of time today talking about problems with the individual market.

We have some, but not much, experience through the states in making the individual market an easier place to buy health insurance. We do not have guaranteed issue in the individual market in most states, and we have all-product guaranteed issue in only a few states.

In some states, we have rate bands, as Mary Nell Lehnard mentioned.[2] But those rate bands can be very broad; five to one or three to one are common rate bands in the individual market. Typically there are bands on health rating, but in most states insurers can rate on age and any number of factors without limit. So the effective rate bands are an empirical question: we do not know what the overall effective rate bands are in most states.

Despite the minimal experience we have in regulating the individual market to make it a "fairer place," we have some experience that is worth noting. We see managed care becoming much more important in states that require guaranteed issue or that limit rating by setting narrow rate bands or requiring community rating. Because we see much more managed care, we see selection against indemnity products, and indemnity products tend to go away.

■ The Value Question

In New York State, with pure community rating and guaranteed issue in the individual market, Mutual held on longer than any other indemnity issuer but finally also went away. Most of the indemnity insurers converted overnight to managed care products, and New York State subsequently put in place a point-of-service mandate for managed care products. But New York's individual market is now a managed care market. Is that better than having a lot of commercial insurers of indemnity products but no access for sick people?

That is just one of the value questions that emerge when we start regulating the individual insurance market. We find that the sick get coverage in these markets and that the healthy people tend to walk away. This is a personal choice but it is also a societal choice. We do not tell individuals that they must have coverage. We tell them they must have auto insurance, but we do not tell them they must have health insurance. Therefore, young, healthy people will buy auto insurance, but they will forgo buying health insurance.

We also have some experience with risk pooling, and that experience is important. Small business pools, organizations that try to buy for very small groups (maybe one to five lives) will tell you that they can only be as good as the larger market. They cannot be a more welcome place to buy coverage because adverse selection will drive them out of business. So, when we talk about proposals to create pools that will be friendly places for people to come, we should worry about the conversion phenomenon Jessica Banthin mentioned.[3] I will convert in order to join your pool if

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[2] *See Mary Nell Lehnard, "The Perils of Unintended Consequences," in this volume.*

[3] *See Jessica Banthin, "Understanding the Current Employment-Based System," in this volume.*

you will pay for my health care and I have no place else to go. Unless we give people who would join that pool other options, all the sick will collect in one place. That may not be a bad thing, but it will focus questions about quality of care and levels of subsidy in one place to be dealt with directly.

Conclusion

The line between Medicaid and private insurance is problematic for a number of reasons. We worry about crowd out, but we also worry about people falling through gaps at the line between Medicaid and private insurance. This is where I take to heart Tom Rice's advice to ignore feasibility[4] and urge us all to look more creatively at this line.

Medicaid is no longer a payer of claims. Medicaid is now a buyer of plans. It has had a difficult start, but there is no major metropolitan area in this country where Medicaid plans to continue simply paying claims for most of its population. Instead, Medicaid contracts with managed care plans in all of these markets, and it will get better at being a buyer of plans as it gains experience at it.

Allowing individuals to buy into those kinds of plans, perhaps with the refundable tax credit, is an idea we need to look at more carefully. Medicaid or CHIP may be places for uninsured low-wage workers to go that might not require broad reform of the individual insurance market. We need to re-examine the line between private insurance and public insurance programs and consider much more creatively than we have in the past the possibilities that a new Medicaid program can provide.

[4] *See Tom Rice, "A Critique of Individual Health Insurance Proposals," in this volume.*

19

Working to a System Based on Choice

by Merrill Matthews, Jr.

■ Introduction

In this book, a number of economists—some of the best health care economists in the country—discuss some of the things that we *can* do with regard to altering the health insurance market place and the tax system. My approach is a little different; I am going to argue what we *should* do. Now, I can argue what we can do; I did my undergraduate work in economics, but then I did my doctoral work in philosophy. So, I am going to take off my economist hat and put on my philosopher's hat and talk about what we should do in the health care market place.

There are perils associated with this direction. Remember the great movie "Anne of a Thousand Days"? It is about Anne Boelyn, who is married to Henry VIII, one of those heads of states with a roving eye. He was looking for a way to get around that problem. One of his advisors named Thomas Cromwell came up to him and said, "I am a lawyer who has read the law." And Henry immediately knew he had somebody who could help him get around the problems that were facing him. Thomas More pulled Cromwell aside and said, "By telling the King what he can do, rather than what he should do, you may have killed us all." Thomas More never stopped telling the King what he should do, and it ultimately resulted in his execution. We will see if the same fate awaits me.

■ Elements of Distortion

Tax policy can be used to achieve desirable goals. Tax breaks allow society to encourage people to act in ways that society deems responsible. We do this for housing through a tax break for mortgage interest. We do it for savings in that you can put money aside in an individual retirement account (IRA) and get a tax break. And there are some ways that we end up penalizing people with the tax system, and we try to go back and change those so we don't penalize what we think might be good behavior. The marriage penalty is one of those issues.

Tax policy, however, can also create certain problems, and one of those is a moral hazard. It encourages people to over-consume, and in health care it will encourage people to over-consume health care or health insurance. Tax policy also can distort the market. The question is whether we should use tax policy that way. The easy answer to that is yes, we should. But there are trade-offs. We have a tax break for people who get health insurance through their employers. That has led to an employment-based system, which leads to the problem of "portability."

People lose their health insurance when they change jobs. That has led folks in Congress to come in and try to solve that problem. They tried to do it with the Kassebaum-Kennedy legislation, the Health Insurance Portability and Accountability Act (HIPAA). But HIPAA has created other problems. It does not work as well as it should. Other people are being priced out of the market. In certain areas, prices are going up much faster, which is leading to an increased number of uninsured.

Thus, the tax system has these distortional elements in it and, whatever we do, we have to be very careful. I do not think we will eliminate the tax break for health insurance. Milton Friedman, the Nobel prize-winning economist, has suggested that we should eliminate any kind of tax break for health insurance, just as there is no tax break for life insurance, and that that will solve most of the problems. I doubt, politically, we will ever do that, and I am not entirely sure that we should.

Whatever we do, if we are going to keep tax policy in the picture, the goal should be to minimize the number of uninsured and maximize choice and freedom in a system that is consistent with the

American economic system and American values. The question is, what kind of tax break accomplishes that? I would argue that the tax credit, a capped tax credit, achieves those goals if it is done correctly.

■ A Capped Tax Credit

First, a tax credit is fairer. The tax exclusion in the current system tends to favor higher-income people more than it does lower-income people. We have people who make a lot of money, who may get an expensive health insurance policy from the employer—may in fact be the employer who provides that huge tax break for himself. A capped tax credit can create fairness across the board, so that you are not favoring those with higher incomes over those with lower incomes. But you have to set the right amount on the tax credit, and that is critical.

This book includes discussion about what that amount should be, and several proposals exist. If you set the tax credit too high, you could ultimately destroy the employer-based health insurance system. Employers looking at this would say, "If people can get a $3,000, $4,000, or $5,000 tax credit if they get health insurance on their own and they don't get that benefit from me, why should I continue to provide health insurance? I would be doing them a favor to let them out in the individual market."

If you set the tax credit too low, you end up creating the problem that no one will use this credit and you have not accomplished anything. So, we should provide enough in that tax credit to purchase a very basic health insurance policy with a high deductible. Some of the proposals suggest a tax credit of between $2,000 and $3,000. One suggests $800 per adult and $400 per child for a maximum of two children, or $2,400 for a full family. In some areas of the country, you could probably get a very basic policy with a high deductible for something around that amount.

The reason you want to cap it at that level is that you do not want to encourage people through the tax system to add on bells and whistles. If people want other options in their health insurance policy, they ought to be able to pay for that themselves, but we shouldn't encourage that through the tax system. You want to cap the system at the right amount to minimize the distortions created with an unlimited tax break—which we have now through the employment-based system—but also encourage people to move into the market.

■ Conclusion

By moving to the tax-credit system, you are going to see more and more people, especially the uninsured, moving into the system. You will see some reconsideration among employers as to what the best system should be. You could even provide employers with the option of moving an employer's whole group out of the tax-exclusion system into the tax-credit system. Thus an employer could make that an option for all of its employees.

But you do want to create a system that is based on choice, so that we can let the market decide. If you do this correctly, the individual market will begin to respond to the various kinds of incentives that are appearing by trying to create a product that will attract people. You also will find that many of the distortions in the current system will begin to fade away.

We may not want to restructure the tax breaks for health insurance too radically at first. This needs to be something that we move to somewhat gradually. But it is the only way for us to get to a system that will be fair for all and get more people insured without destroying the current health care system.

20

Underrating Empires

by Len Nichols

■ Introduction

Why I Am Less of an Economist and More of a Conservative Than I Was When I Came to the May 1999 Employee Benefit Research Institute Policy Forum.

To begin with a bold statement, the virtues of empires have been underrated. I will reach to the somewhat painful, but timely, example of the Ottoman Empire. For 500 years, the Ottomans ruled southeastern Europe. And, plus or minus a little conflict around the edge, there were no problems with the Serbs. In the 19th century, the Ottoman Empire, of course, was the sick man of Europe. The great powers spent all their time trying to figure out how to manage the decline of the Ottoman Empire because if it declined too fast, untold Pandora's boxes would be opened. And, if it declined too slowly, different kinds of problems would occur. In the last 100 years, Serbia has been free of Ottoman rule. In that time, Serbia started World War I, started World War I, and in the last decade, it created still untold amounts of pain and suffering. So, this discussion raises the question, is the employment-based system like the Ottoman Empire, the sick man of the American health care financing system?

■ Tax Preferences Are Not the Problem

Let me remind you of where I started, which is why I am less of an economist. Every economist is taught the same thing in grad school. We wake up every morning and bow down to the east and say the same thing: Tax preferences are a bad idea. Martin Feldstein[1] that blames tax preferences for excess health insurance and excess health insurance, of course, is the fundamental source of evil as we know it in this country. I would just point out that only an economist could look at a society with 40 million uninsured and conclude the fundamental problem is too *much* insurance. There is something wrong with this world view.

The problem is not too much insurance. The problem is poorly distributed insurance. That is why I like the way Stuart Butler[2] described the goals behind this movement, to try to redistribute some of this tax preference money in a way that makes more sense.

The second little chink in the economist's armor that I feel compelled to observe is that we are always taught that there is a 100-percent wage offset. That is, employers in theory should be indifferent about whether or not they offer compensation in wages or in health insurance. After all, a dollar is a dollar. Why do people get so excited?

I would propose to you that the proof that the economists are wrong about a 100-percent wage offset is that employers spend so much time developing the expertise to buy insurance. If they were indifferent, why would employers bother? Why would they care about what kind of insurance you buy unless they were somehow sharing at least some little portion of that excess they have chosen to provide? Given this employer effort, there cannot be a 100-percent wage offset. It must be something less than that, and that is what fuels the employer's compelling interest and why employers are trying to get better at it, although they are not as good as we would like, of course.

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[1] *See Martin Feldstein,* Hospital Costs and Health Insurance *(Cambridge, MA: Harvard University Press, 1981).*

[2] *See Stuart Butler, "A Plan for Individual Health Insurance," and "View from a Think Tank," in this volume.*

Expanding Subsidies

Having decried my profession's embarrassments, the good news is that no one is proposing that we simply abolish the current tax treatment, although Martin Feldstein would abolish the current tax treatment if he could. No one really is seriously talking about that inside these proposals. Therefore, any fool would support expanding some kind of subsidy in the market for people who are outside the employment-based system. If that is what we are discussing—how to design something for the currently uninsured, those who are not offered employment-based insurance—I believe you will find a great deal more support and intellectual engagement than one might have anticipated.

The fact that no one is talking about completely abolishing all tax preference but rather changing the nature of it simply acknowledges an implicit acceptance of the point that there is good reason to collectively subsidize health insurance. There are some externalities. The single biggest externality of what we have chosen to do with our tax preference for health insurance is exactly the phenomenal system of health care delivery we have out there.

One man's excess is somebody else's opportunity. All those extra dollars we threw out at the providers were sucked up in anticipation of what? Selling goods and services that had some value. The reason we have this marvelous laser technology is precisely because we did not do what Carl Scott[3] talked about in 1972, where they argued about whether a doctor's visit is $8 or $15. If we were still paying $8, there is no way we could be doing the surgery we are doing today. So I would just say the major externality was the delivery system that grew out of the funding that we chose to marshal toward it. We should think about that little pocket of empire before we dismantle it completely or precipiteously.

What does a true conservative, which I have now become, really want to think about when looking at this kind of policy proposal? Well, obviously conservatives, as I remember them being described, are people who are cautious about change, cautious about abandoning existing systems that work pretty well, cautious, if you will, about abandoning an empire.

Three Things to Preserve

There are the three things that we really want to keep which the current employment-based system provides. First, I would submit, as mentioned by others, the economies of scale in purchasing, both on the employer side of administering the benefits and on the insurer side of selling those benefits to larger groups as opposed to individuals. The amount of money, as Mark Pauly's and Brad Harry's work[4] makes clear, reminds us all that there is a large amount of money in administrative efficiencies, and we should never forget that.

The second feature we want to hold onto is some kind of risk pooling, a concept shared by many. We might differ about the degree, and we might differ about whether rate bands should be here or there. We all agree mostly that it should not be completely pure. But we want to have some kind of risk spreading, or risk pooling. We should think about the employment-based system as the glue that holds risk pools together.

And I would just make a brief aside about Mark Pauly's most recent empirical work, done for the American Enterprise Institute. I cannot wait to read it. But I believe what he found is that the individual market is not as bad as we thought, and the group market is not perfect. Both things are still true, but it does not follow that the individual market is as good as the group. I would also point out that the National Medical Expenditure Survey data Pauly used does not include prices faced by people who could not buy individual health insurance, and that is the fundamental problem in that unregulated market. I believe I will stand by the conventional wisdom (for at least a little while) that it is better to have group than individual insurance.

The third feature of employment-based systems that we want to maintain, particularly given what we have seen in the last 15 years and the last 10 in particular, is purchasing expertise. As another analyst observed, these involve both organized purchasing and value-based purchasing.

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[3] *See Carl Scott, "One Company's Experience With Regulation," in this volume.*

[4] *See forthcoming study by Mark Pauly and Brad Harry (American Enterprise Institute).*

In particular, just look at something like the Health Plan Employer Data and Information Set (HEDIS). Whatever you may think of the specific measures, the very idea that this many employers, this many health maintenance organizations, and this much of our country could come to a consensus implies that this is a reasonable set of things to collect. This is major progress over where we were before. We do not want to throw that away. We want to hold on to economies of scale, risk spreading, and organized purchasing that is value-based and makes some sense.

That brings us to the question of how we could do this outside an employer-based system. The simple way is to have purchasing coalitions and some kind of insurance reforms. We did try this once. It was called the Clinton Plan, and we got our heads handed to us for proposing it. Do you really want to go to a world where you have to have insurance reforms and some kind of purchasing coalition to make this work? I would submit to you the reason we are not there now is because the employer market has worked well enough to obviate the need to bring this kind of power to bear, and that is why we like the employment-based system so much.

■ Conclusion

Returning to the analogy of the Ottoman Empire, the larger agenda here is that it is clearly a good idea to empower the individual. That is what is most appealing about both Merrill Mathew's arguments[5] and everything that has to do with individual tax credits. There is no question that we could have done a whole lot better job of that in the past, and I applaud his work and others in trying to figure out ways to do that pragmatically and reasonably as we go forward. We want to empower individuals.

But we do not want to weaken the organized purchasing power that we have come to rely upon. We do not want to go back to strengthening the physicians and the individual insurers who used to have a lot more power and abused it, to some degree. I would submit that there was a reason the Ottomans kept the Serbs down. There is a reason why employers have gone after the power of providers and insurers. That is, you get better value when you counterbalance provider and insurer power as opposed to restoring the old power structure, which is what some individual-based proposals would dangerously do. I prefer the empire I know, for it has served us relatively well.

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[5] *See Merrill Mathew, Jr., "Working to a System Based on Choice," in this volume.*