A PLAN FOR 'RESPONSIBLE NATIONAL HEALTH INSURANCE'

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Prologue: *In December 1975, at a hearing convened by a House health panel, Chairman Paul Rogers declared: "Today the Subcommittee on Health and the Environment begins its consideration of national health insurance–a concept which was articulated more than 25 years ago by President Truman and one which, as health care costs spiral and as more and more gaps in health care coverage are identified, has far-ranging implications for every segment of our society. . . . At the same time that this country is spending nearly $120 billion each year–or about $547 per person per year for health care–approximately 25 million Americans have no health care coverage, public or private." The numbers have changed since 1975, but the issues remain largely the same: How to provide universal access to medical care to all Americans at a politically acceptable cost? During that fifteen-year period, the confidence in the capacity of government to effectively administer a national health plan has diminished, thus giving proposals that rely on alternative approaches greater weight. One such proposal is that offered by Mark Pauly and Patricia Danzon, both of whom are economists at the Wharton School and the Leonard Davis Institute of Health Economics, University of Pennsylvania; Paul Felstein, an economist at the University of California, Irvine, Graduate School of Management; and John Hoff, a lawyer in private practice in Washington, D.C. Their plan is based on a belief that the allocation of resources to health care should rest on individuals' choice of insurance, in light of their different needs and desires. This will drive a competitive market and improve the efficiency of the health care system. Individuals would be required to obtain a basic package of benefits geared to their ability to bear health care costs and would be given government assistance as necessary to purchase such insurance.*

With a significant fraction of the U.S. population lacking health insurance and serious inefficiencies existing in the health care delivery system itself, national health insurance is under consideration again. Some proposed remedies may offer some improvement over the current system. But we question whether any will appropriately serve American values or efficiently provide the full set of changes that are needed.

Any plan for reform should, in our view, be judged by whether it promotes efficiency and appropriate equity in the health care system. In this article, we outline a system that we believe would best achieve those objectives. Most of the new national health insurance proposals, like versions of national health insurance that have been proposed for decades, assume that substantial government involvement in the health care system is necessary to assure insurance coverage for all Americans and appropriate growth in health care expenditures. Our view is that excessive government intervention will make matters worse. Our strategy, therefore, is to design a scheme that limits governmental rules and incentives to the extent necessary to achieve the objectives.

A plan that combines governmental assurance of universal coverage with financial assistance as needed to achieve this coverage, in an institutional framework that encourages a vigorously competitive market, would best achieve the objectives of efficiency and equity. Such a market enables all persons to act on their quite different desires for health care and their willingness to forgo other goods and services for health care, should they choose to do so.

Efficiency And Equity

Any proposal for national health insurance must, in our view, ultimately be based on principles of efficiency and equity. Efficiency has two important dimensions: (1) minimizing the cost of whatever set of services are provided; and (2) choosing the level, quality, and mix of medical services, relative to other goods and services, that lead to the maximum excess of benefits over costs. Efficiency thus reflects a set of choices in which the resources used to furnish all goods and services yield maximum value to consumers. This definition of efficiency includes the valuation of quality, and the tradeoff with cost, as part of the objective to be sought.

The second dimension has an important and profound implication: an efficient system does not necessarily have the lowest budget cost. The most cost-constraining system is the one that incurs no cost, but this is obviously not desirable. Nor is a strategy that has contained costs in other countries necessarily desirable for the United States. Similarly, our

system's "failure" to achieve a zero rate of growth in real cost, a rate equal to the growth of gross national product (GNP) (which would keep health care's share of GNP constant), or a rate as low as a regulated system in some other county, is not necessarily a deficiency. The appropriate objective is the *right* rate of growth in cost. That rate, in turn, depends in large part on the value that informed consumers attach to costly but beneficial new technology and to the use of health services. If a costly new technology is valuable in relieving pain and discomfort or in reducing morbidity or mortality, a high rate of growth in cost–and the rising fraction of GNP that may accompany it–are cause for cheer rather than concern. The higher cost reflects the greater benefits of higher quality. Whether rising expenditures are desirable depends on a comparison of value to cost.

Equity has a less precise meaning; neither economics nor logic can prove that one person's definition of fairness is necessarily superior to that of another. It is generally agreed, however, that horizontal equity (equal treatment of persons with equal real incomes) is desirable. A person should not be able to pay lower taxes simply because he or she can obtain health insurance in connection with employment. It is also generally agreed that any income redistribution through the tax system should be from those with more to those with less–vertical equity. But precisely how tax rates and public benefits should change as real income increases is much more debatable. We believe our country's current mildly progressive tax structure and highly progressive distribution of government welfare and transfer benefits should be maintained, and that the current regressive system of tax subsidies to health insurance is an anomaly to be corrected.

Proposed Plan For National Health Insurance

To improve the efficiency and equity of the American health care system, we propose a national health insurance plan that would guarantee coverage for all without unnecessary and unfair cross-subsidization, that would increase the efficiency of health care delivery and thus make more health care benefits available to more Americans, and that would provide the flexibility and freedom necessary to stimulate technological and administrative innovation. The plan we propose properly recognizes both the responsibilities of citizens to have adequate medical insurance and the need of some to receive financial assistance to make this insurance affordable. Our plan supports and makes use of competitive markets; it avoids relying on the public tax or expenditure systems whenever possible, to minimize tax-side distortions and to recognize the current

constrained nature of government budgets. Our approach would permit informed individual preferences to determine the allocation of resources to health care; it would encourage the development of innovative and efficient forms of delivery; and it would advance the vitality and quality of the health care system. We call this plan "Responsible National Health Insurance."

Underlying assumptions. Our plan is based on eight assumptions. (1) Every person should be able to obtain health care on a timely and systematic basis. Society currently provides some level of care to some of the uninsured through a haphazard combination of uncompensated care and varying Medicaid eligibility. It would be more effective and humane for recipients and less costly for society if assistance came in the form of affordable insurance rather than payment for care when delivered in the late stages of illness.

(2) A monolithic, government-run system is not necessary to provide universal health insurance. This can and should be accomplished instead through competitive markets, with government intervention only as needed to make markets work and to provide financial assistance.

(3) All citizens should be required to obtain a basic level of health insurance. Not having health insurance imposes a risk of delaying medical care; it also may impose costs on others, because we as a society provide care to the uninsured. The risk of shifting costs to others has led many states to mandate that all drivers have liability insurance. The same logic applies to health insurance. Currently, those who obtain insurance, usually by taking a job that comes with health insurance benefits in lieu of cash wages, subsidize those who remain uninsured, whether or not by choice. Permitting individuals to remain uninsured results in inefficient use of medical care, inequity in the incidence of costs of uncompensated care, and tax-related distortions.

(4) The obligation to obtain basic health insurance should be placed on the individual, not on the employer. This achieves universal coverage with high flexibility at low cost. It avoids interfering with labor markets and employment contracts; it facilitates portability of coverage, employment mobility, and a competitive market. Placing the obligation to obtain coverage on the individual does not limit the freedom of employers to offer group coverage as a fringe benefit. Indeed, the great majority of the population would probably continue to obtain insurance through employment, because of the substantial administrative cost advantages of employment-related group insurance in large firms. Moreover, group insurance is often the vehicle for helping individuals screen and choose among a variety of health plans; employee benefits managers have strong incentives to act as efficient agents for employees. An individual could

take a job that does not carry health insurance, provided that he or she otherwise obtains the minimum level of insurance. Employment-based insurance is not necessarily the lowest-cost way to cover employees of small firms, which do not enjoy the scale economies of large groups; it can lead to excessive uniformity within a firm and to potential inequity. It also offers the unfortunate appearance that the employer pays for the insurance, whereas employees actually bear the cost by receiving lower money wages.

(5) The government should provide the financial assistance necessary to make the required coverage affordable to all. This should be achieved through a system of federal income tax credits of prespecified amounts related to income, for which all would be eligible regardless of employment status. These tax credits would reduce income taxes and would be "refundable" in the sense that, if the credit exceeded an individual's tax liability, the excess would be refunded to the individual. This would replace the current system whereby employer contributions to health insurance are tax-exempt income to employees, without limit and without regard to need. This current system is horizontally inequitable, since only the employed are eligible. It is vertically inequitable, since the subsidy is higher for high-income individuals and for those who buy more lavish insurance. It is contrary to the public interest; by permitting the purchase of insurance with pretax dollars, it encourages people to buy more insurance than they need, thus fueling health care inflation. Government tax policy toward health insurance should be directed at making adequate insurance affordable for all, with minimum tax cost to the U.S. Treasury and minimum distortion in marginal choices of individuals. This can best be achieved by requiring individuals to have appropriate coverage, while using fixed-dollar tax credits geared to need to achieve the desired degree of affordability and equity. To leave in place the current tax treatment of insurance or to extend it to subsidize everyone's purchase of insurance would perpetuate the present vertical inequity and impose a tremendous drain on the tax system, the real cost of which is the additional incentive distortion that taxation imposes on Americans.

(6) The required minimum level of financial protection should be based on a family's income. Higher deductibles and out-of-pocket limits would be permitted for persons with higher incomes because they could absorb such costs without risk of underusing care or generating bad debts. Allowing higher-income individuals to pay a larger percentage out of pocket could benefit everyone, since paying for care out of pocket results in more cost-conscious use, which in turn creates incentives for providers to keep fees and costs down. Individuals could, if they wished, purchase more complete coverage than the minimum required for their income

level, provided that they paid the cost of the additional coverage.[1]

(7) Some modest increase in taxes will probably be needed to pay for the proposed expansion of coverage and tax credits. The amount would depend on choices about the generosity of the structure of tax credits, in particular, and on the political will to cut back the current tax subsidies to middle- and high-income individuals. Our proposal relies on a visible and equitable source of financing. This contrasts with the hidden and inequitable financing of mandating employment-based coverage or the present unfair and inefficient system under which care for the uninsured and Medicaid beneficiaries is financed in large part by *a de facto* excise tax on hospital charges paid by the privately insured, without regard to ability to pay.

(8) A vigorous, competitive market in insurance and in health care delivery is more likely to create an efficient and high-quality health care system than is one controlled by government. An improved market system, purged of open-ended subsidies, free riding, and cost shifting, is the most appropriate way to determine the allocation of resources to health care. A more efficient system would permit us to produce more real health benefits or other goods and services within our given resources. Placing the obligation to obtain insurance on the consumer would achieve universal coverage without distorting labor markets; it would encourage cost-conscious choices and a competitive market in which individuals (and employers on their behalf) have an economic interest in the selection of their insurance.

Plan Characteristics

Mandatory basic coverage. In our scheme, every person would be required to obtain basic coverage, through either an individual or a family insurance plan. All basic plans would be required to cover specified health services; plans could, however, offer more generous benefits or supplemental polices. The maximum out-of-pocket expense (stop-loss) permitted would be geared to income, with more complete coverage required for lower-income people, to ensure that no one faced the risk of out-of-pocket expenses that were catastrophic, given their income. Again, more up-front protection could be chosen if desired.

Requirements for insurance plans. All insurance plans must provide at least the minimum benefits specified by the government. These should include basic acute care services and a specific set of preventive services that are known to be cost-effective and beneficial. All plans would also be required to provide out-of-area coverage in emergency situations and comply with any requirements concerning selection. A plan could not

require deductibles, copayments, or maximum out-of-pocket payments in excess of the levels specified by the federal government, which would depend on the policyholder's family income. (This might be most easily administered by segmenting plans according to the generosity of coverage.) A possible design option would be to designate particular plans or self-insured benefit structures as "qualified" to satisfy the coverage requirements at different income levels.

A plan could offer benefits beyond the required minimum or could require less out-of-pocket cost, with an additional premium charge, for those consumers preferring more extensive coverage. Alternatively, add-on benefits could be purchased through supplemental policies, for example, for dental and vision care.

Fallback coverage negotiated by the government. The government would solicit bids from plans in each area to provide the required minimum coverage for a specified premium for each rating category and each level of maximum permitted out-of-pocket expenditures. One or more plans in each area would be designated by government and would serve as "fallback" coverage for those who did not obtain coverage in the private market. The insurer might specify premiums for different rating categories; higher-risk individuals would obtain fallback coverage through a subsidized assigned risk pool. The government would have to accept a sufficiently high bid to attract at least one insurer to serve as fallback insurer in each area.

The fallback insurer would provide coverage in two situations. Some individuals might choose to obtain coverage from this insurer rather than from other private insurers. Others would automatically receive fallback coverage because they had failed to buy coverage individually; these persons would have a premium collected through the tax system.

Universal tax credits or vouchers. The current system whereby employer contributions to health insurance are tax-exempt compensation to employees would be replaced by a system of refundable tax credits (which are effectively vouchers for persons with little or no tax liability). Congress would choose the level of the tax credit at each income level. The credit would be related to the premium for the required coverage and would be inversely related to a family's income. The credit also would be adjusted to reflect each family's risk category.

The current tax treatment of health insurance is horizontally inequitable because it depends on employment status and employer contribution. It is vertically inequitable because the subsidy per dollar of insurance premium is higher for persons paying higher combined marginal income and payroll tax rates. Open-ended tax exclusion implies larger subsidies for high-income workers and those who choose more generous benefits.

Our plan would treat any employer premium payments as part of taxable compensation, to be reported on the employee's W-2 form. Tax credits toward the purchase of the obligatory coverage would be provided to all, based on income, regardless of how insurance is obtained.

The net effect of this change on the cost of a family's health care and health insurance would depend on the level of the tax credits adopted. But we anticipate that lower-income persons who currently obtain either individual or employment-based group insurance would enjoy a net reduction in taxes, since their tax credit under the proposed system would probably exceed the current value to them of the tax exclusion. Indeed, at low income levels, the tax credit would equal the premium; the insurance would be wholly financed by the government. Higher-income employees, who benefit most from the current tax loophole, would pay higher taxes on balance; this would be an important revenue source for financing the new subsidies to the currently uninsured. The tax credit would be set at zero for sufficiently high income levels; at the same time, the required level of coverage and hence the premium for the mandated plan would also decline with income.

Out-of-pocket expenditures. If a family came close to the maximum permitted out-of-pocket expenditure level in more than one year, the maximum permissible level would be lower in future years to avoid the cumulative effect of several years at the maximum permitted amount. Balance billing should be an option to be determined by negotiation between insurance plans and providers.

How The Program Would Work

Employed individuals and their families. The arrangement between the individual and the employer for payment of premium and choice of level of coverage beyond the minimum would be left to employment negotiations. The employer might simply pay (part of) the group insurance premium with an implicit or explicit reduction of the cash wage, in which case the contribution would count as taxable income to the employee. Alternatively, there might be an explicit check-off from the paycheck, or the individual might pay the group insurer directly. The employer would report the type of coverage the employee obtains and employer contributions (if any) on the employee's W-2 form. If this insurance was at least as comprehensive as the obligatory level, the individual would satisfy the minimum insurance requirement and would receive the tax credit, based on his or her income inclusive of any employment-related premiums.

If the employer did not arrange a health plan that met the obligatory

standards, employees would be required to present evidence that they had obtained the obligatory coverage as part of filling out the W-4 tax form to determine federal income tax withholding from wages. If no evidence of coverage was provided, an additional amount to pay the premium for insurance would be withheld from the paycheck, along with the conventional withholding for federal income tax purposes. Individuals would then be covered by the fallback insurance, and the amount withheld would go toward the fallback insurance premiums. The net amount withheld would depend, of course, on both the premium negotiated by the government and the level of the individual's tax credit. In multiple-worker families, only one family member would need to obtain coverage.

The self-employed. The self-employed currently are allowed to deduct 25 percent of any health insurance premiums (in contrast to the 100 percent deduction for employer payments on behalf of employees). This deduction would be replaced by the universal system of income-related tax credits. The self-employed would be required to obtain coverage but could adjust their estimated tax payments to reflect the expected credit due. If they failed to obtain coverage, they would be required to include their expected net premium payment (for the fallback insurance) in their prepayment of estimated taxes. Failure to pay this premium as part of one's estimated tax would be subject to the same penalties as are currently applied for underpayment of estimated taxes.

Persons who are not employed. Dependents would be covered through a family plan of an employed family member. Those not covered through an employment-based family plan would be required to obtain coverage. Those with incomes large enough to have positive tax liabilities could reduce their prepayment of estimated taxes, to reflect the expected tax credit for insurance premiums.

Persons whose incomes are sufficiently low to have no tax liability could purchase coverage and file to receive the refundable credit owed them. However, many low-income individuals could not afford to pay the premium cost out of pocket, even if they were entitled to a full refund at the end of the year. The local welfare agency would verify income status, collect the net premium payment due from the individual (if any), and issue the individual a voucher or advance for the cost of coverage, which could then be used to enroll either in any private plan or in the fallback plan. The welfare agency would receive the tax credit due to the individual. If such an individual was receiving government cash assistance, any net premium contribution due could be withheld from his or her cash payments. Using local welfare agencies to verify income and issue a voucher draws on a bureaucracy that is already set up to verify income status and would facilitate prompt enrollment of poor individuals who

could not afford or simply failed to obtain coverage on their own.

Medicaid and Medicare. Medicaid would be replaced by the proposed system under which persons now eligible for Medicaid would probably be eligible for a subsidy equal to the full cost of coverage. They would register at the local welfare agency and receive a voucher equal to the cost of coverage. A distinct advantage of our plan is that it would eliminate the notch disincentive currently faced by Medicaid eligibles who lose their health coverage completely if they earn income sufficient to raise them above the eligibility threshold. States could initially be required to maintain their current level of Medicaid expenditures for acute care, contributing those payments to a fund used to pay tax credits to residents of their state. To provide equity across states, these contributions could be either phased out over time or maintained on an equalized basis.

This system could eventually be applied to Medicare. Rather than changing the system for current Medicare beneficiaries, this system could apply to persons as they age into Medicare eligibility (starting perhaps with those now age fifty-five, to apply when they become Medicare eligible).

Adverse And Preferred Risk Selection

Adverse selection occurs when the policyholder is better able to anticipate expenses than the insurer. Because our plan obligates individuals to buy the required coverage, adverse selection is impossible in the market for the required coverage. This is a critical feature that distinguishes our plan from Alain Enthoven's Consumer Choice Plan.[2] (Adverse selection might persist in markets for supplemental insurance. Since this is optional coverage, however, it is not a matter of social concern.)

Incentives for preferred risk selection, on the other hand, might remain. In competitive insurance markets, insurers tend to charge higher premiums to persons they judge to be high risks and lower premiums to those they believe are low risks. Permitting insurers to vary premiums by expected cost can, in principle, have the beneficial effect of rewarding and therefore encouraging risk-reducing behavior, such as not smoking. But some factors that make individuals high risk are beyond their control. It may be considered politically unacceptable to have the sick pay higher costs for coverage, particularly as ill health may also have reduced their ability to work. (Of course, if they are unable to work, their tax credit will automatically increase as income falls.) In the limit, high-risk individuals may be unable to obtain coverage at premiums they can afford. Clearly, a national health insurance plan that relies on private insurance markets must address these possible negative effects of competitive markets.

The ideal solution would be the rating of both premiums and tax credits on the basis of risk factors. Insurers would charge people at all levels of risk their expected cost of coverage, and the government would also adjust tax credits according to expected cost. If the government has the same information in setting credits as do insurers in setting premiums, this process could eliminate unintended differences in the out-of-pocket cost of coverage among individuals.

As a practical matter, perfect alignment of rating of credits and premiums may not be feasible. It is quite feasible to rate tax credits on the basis of age, gender, region, and certain other objective actuarial categories, such as specified diseases. But if the information available to the government in setting credits is less complete than that used by insurers in setting premiums, higher-risk individuals within tax credit categories will pay higher net costs for coverage.

It is an empirical question just how severe this after-credit variation in net premium cost among individuals would be. It might be reduced by permitting individuals to trigger an additional credit by showing that they had paid a premium that is above the standard rates a company charges. To prevent fraudulent conspiracy between the individual and the insurer, the credit would have to cover only part of the additional premium, but a small "copayment" might be sufficient to deter abuse.

Community rating. An alternative approach for reducing health-related premium cost differences is to require all insurers to practice community rating; that is, to charge all individuals the same premium, regardless of health status or other risk factors. Several degrees of community rating are possible. At one extreme, full community rating would require uniform premiums for all individuals. This is objectionable on two grounds.

First, community rating would greatly exacerbate insurers' incentives for preferred risk selection, unless it were combined with very effective regulation ensuring open enrollment and uniform rates for all insured people. With unrestricted competitive rating, insurers have no reason to reject high risks if they can charge an adequate rate and have no incentive to market aggressively to low risks if rates for low risks are bid down to competitive levels. By contrast, with full community rating, insurers necessarily lose money on above-average risks and make a profit on below-average risks; thus, their incentive is to skim low risks and avoid high risks.

Second, although community rating has a superficial appearance of equity, it is in fact highly inequitable. Subsidies to high-risk individuals are effectively financed by an implicit tax (premium above cost) paid by low-risk individuals, regardless of their respective income status and

ability to pay. It is by no means true that all high-risk individuals are poor or that all low-risk individuals are well-off. The inequity is exacerbated, in a way that cannot be offset by income-related tax credits, if the implicit tax on low risks and subsidy to high risks depend on the relative number of sick and healthy individuals in their insurance plan.

The disadvantages of community rating could be reduced by requiring such rating only within actuarial categories based on a set of objective predictors of expenditures (such as age, family size, and the presence of certain diseases). The credits would be adjusted for their specific categories. Insurers also might be permitted (or encouraged) to define categories without tax credit adjustments for individuals or firms that engage in health-improving activities or put smokers into surcharged categories.

Design choices. To the extent that the set of categories insurers would want to use differs from the set of categories the government wants to permit, the disadvantages of community rating remain to some degree. The real issue here is an empirical one: How divergent would firms' preferred categories be from those the government would choose? In practice, the degree of fine tuning of tax credit categories involves a tradeoff between the administrative costs of fine tuning and some residual unfairness if insurers use finer rating categories. Within-category variation in premium costs to individuals may persist, because the administrative cost of eliminating it is too great.

It remains an unanswered empirical question whether there really will be a serious problem, either of unfairness or of regulatory burden, under either approach. The simplest policy would be to use the least interventionist option initially–that is, full and free risk rating for insurers–but permit individuals to claim some adjustment of tax credits according to health-related categories such as age, gender, and specified conditions. Requiring guaranteed renewability of coverage at standard class rates for individuals and small groups could be a condition of the required coverage for all basic plans, so that the problem of high premiums or unavailability of coverage for high risks would diminish over time. But if experience should indicate that, even then, high risks still face unacceptably large differences in after-tax premium costs, some degree of regulation to create actuarial categories and to require more uniform rating of these categories could be introduced.

We believe it would be inappropriate policy to hold coverage reform and the benefits of competitive markets hostage to the threat of what may amount to a modest amount of preferred risk selection, given the protections we have suggested. Heavy regulation to prevent a little risk selection is unlikely to be cost-effective and may be very hard to reverse.

High-risk pools. To supplement the risk-rating approach, it might be

necessary to set up explicit high-risk pools, subsidized and independent of the fallback insurer, to cover any persons who might have been rejected for private coverage. Such pools would charge premiums below the actuarial cost, thus providing some subsidy in addition to the tax credit, so that individuals using the pool would pay a premium that is regarded as equitable (given their income). Federal general revenue taxation would make up the deficit in the pool. However, the design of the administrative structure and the benefits offered should preserve incentives for the pool and for providers to operate efficiently.

With risk rating of tax credits and the preservation of a competitive insurance market, the high-risk pool is likely to be used by only a few very high risk individuals. However, it will serve the role of guaranteeing that adequate coverage at reasonable (postcredit) premiums is available to all.

Patient protection measures. Self-insured firms should be subject to the same tax and regulatory provisions as commercial insurers under the law establishing this plan. This applies to solvency requirements, requirements for basic coverage, and provisions for guaranteed renewability if adopted. State-mandated benefit laws, which currently apply to commercial insurers but not to self-insured firms, would be preempted. Also, a patient protection fund, administered by either the states or the federal government, would be created to compensate enrollees for benefits due in the event that a plan became insolvent. The fund would be financed by assessments on insurers and the benefit payments of qualified self-insured firms. Finally, an independent commission would be created to evaluate the program's performance and to recommend any changes.

Advantages Of Our Approach

Adequate coverage for all. Our proposal guarantees adequate insurance coverage for all. Other strategies that rely on subsidies to induce people to buy coverage voluntarily have two defects: they necessarily end up paying subsidies to people who would have bought coverage anyway, and they would surely leave some fraction of the population uninsured. Our approach imposes an obligation to be covered and uses the tax system, supplemented by welfare agencies, to ensure that all receive appropriate coverage and subsidies and that all can pay their bills.

Of course, requiring coverage implies restricting individuals' freedom to remain uninsured. Given the potential social ramifications of such decisions, we believe that the benefits of this restriction outweigh the costs. As a society, we already restrict individual choice and require insurance against costs of retirement and disability (Social Security), automobile accidents (mandatory automobile insurance in many states),

workplace injuries (the workers' compensation system), unemployment, and other smaller programs. All of these programs effectively mandate some minimum level of coverage and then leave individuals free to purchase supplemental coverage. The same logic should be applied to medical care and health insurance.

Minimal disruption of current arrangements. This approach does not disturb existing insurance arrangements for the great majority of Americans. Polls consistently show that Americans are dissatisfied with their health care system as a whole but satisfied with their own situation. Most Americans currently have insurance at least equal to the minimum level of coverage that we envisage. They usually receive this insurance through their employment. Although our proposal places the requirement to have insurance on the individual, it does not require each person to buy insurance individually; insurance may be purchased through an employment group, and employers will have strong incentives to select plans that best meet the preferences of their employees. The replacement of the open-ended tax exemption by a predetermined tax credit should be a powerful stimulus to employees and benefits managers to make efficient choices among insurance plans that meet the minimum standards and make cost-conscious choices of supplemental benefits. We anticipate that most medium and large employers would offer several options that provided the required minimum benefits, in the form of fee-for-service and managed care options. Within this framework, differences in copayment and stop-loss could easily be accommodated. Supplemental coverages might also be offered.

Individual preference. This plan permits arrangements tailored to differences in needs, tastes, and resources of individuals. No single form of care delivery, type of health maintenance organization (HMO) or preferred provider organization (PPO), or method of reimbursement is unequivocally best for everyone. Our scheme fosters diversity, by locating the initial obligation to buy coverage at the individual level; by permitting the individual to discharge that obligation through employment-based insurance, private purchase, or use of the fallback insurance; and by placing only minimum restrictions on services covered and out-of-pocket costs.

Flexibility. There is maximum flexibility in the level and distribution of the subsidy to pinpoint the subsidy. Subsidies to encourage coverage may be either more or less generous than the level that would be needed to achieve an equitable distribution of after-premium income. In our arrangement, the law mandating coverage can be tailored to achieve the desired level of coverage, by income class. Tax credits can then be used to offset the premium for this coverage to yield a distribution of net cost

that can meet any notion of equity. From an economic viewpoint, we cannot define what is equitable; that is a design question for the political process. But whatever is decided can be easily implemented (and changed) within the framework we have suggested.

Removal of existing distortions. The current tax treatment of health insurance strongly subsidizes insurance in the employment setting. By eliminating the open-ended exclusion and replacing it with a fixed, income-related credit that is independent of how much insurance coverage or medical care a person buys, we ensure that price signals reflect true resource costs.

Distortions associated with mandated "employer-provided" insurance are also avoided. Requiring the purchase of some service for public benefit is formally equivalent to financing a public expenditure with a head tax. But in the case of health insurance, which is favored by the tax exclusion, financing is even more regressive than a head tax. The well-to-do actually pay less than those with lower incomes. Moreover, much of the cost of mandated benefits ultimately will fall on workers in the form of lower cash wages or fewer jobs. Mandated employer coverage will, in the first instance, cause employers to desire less labor, which will depress either money wage rates or employment. The analysis is complex and uncertain as to how costs will ultimately be distributed between employers, consumers, and employees, but the best bet is that the bulk of the cost will fall on employees. Roughly a third will be borne by federal and state governments, through forgone income and payroll taxes.

Contrast this view with the general belief that mandating employer coverage makes "rich" employers pay and the strong temptation that that belief, together with the hidden nature of government costs, offers to politicians to expand benefit mandates. Our approach puts the costs in the first instance where they are likely to end up in any event. Politicians could still determine the level of coverage. But we suspect that the obvious cost of "giving" people more coverage will lead to more rational comparisons of costs and benefits than if coverage is mandated on employers and the cost to employees and taxpayers is hidden.

Responses To Potential Criticisms

Some critics state that varying the minimum benefit level with income is administratively too complex. By tying the enforcement of the minimum coverage requirement directly to the federal income tax system and the welfare system, the administrative cost of varying coverage with income can be greatly reduced. The same system that determines whether a person has coverage at all also determines whether that person has the

level of coverage appropriate for his or her income.

Others maintain that employers will stop offering policies if the mandate is put on employees. This is implausible. The elimination of the tax exclusion applies to the worker, not to the employer; the employer can continue to deduct insurance premiums as part of total compensation cost. Since the employer's cost is left unchanged by the new program (tax credits go to the employee), and since the employee's productivity is not changed, there is no reason why the employer would want to reduce current coverage. If employees can obtain coverage at lower cost because of the scale economies of group coverage, they should choose to continue such coverage rather than switching to individual insurance.

A third criticism is that employers not currently offering coverage will not be willing to offer group coverage even though employees would prefer it. To induce the employer to arrange additional coverage–if employees regard the group coverage option as preferable–employees would have to be willing to accept lower cash wages or to pay the premium directly by turning some part of their wages over to the insurer. There is no reason the employer should not be willing to help arrange coverage. Indeed, once an obligation to buy coverage is put in place, employers who do not currently offer insurance may well choose to do so, if employment-based coverage is indeed more convenient.

Finally, some critics fear that individuals will not be able to make informed choices among plans. We envision that most persons will continue to make choices in an employment-related setting, in which paid benefits managers assist in selecting plans to be offered and in deciding whether there are to be multiple options. While we offer no artificial incentive to select employment-based coverage and the advice that goes with it, we anticipate that most people will continue to use this method. Since the required coverage will have to meet government-imposed standards, buyers are unlikely to be defrauded. In selecting a fallback insurer, the government will also presumably act as a well-informed and prudent purchaser.

Comparisons With Other Plans

Nationalized health systems. There are basically two other approaches to ensuring universal coverage. The first establishes a public monopoly of basic insurance that provides uniform coverage to all citizens, with financing from general tax revenues, as in Canada and the United Kingdom. The claimed advantages of this approach are that it achieves universal and uniform coverage with apparent administrative simplicity. But some of the claimed advantages are more apparent than real, and

there are real disadvantages. The experience of Medicare and Medicaid, which are both public monopoly insurers for their targeted populations, indicates that administration is far from simple. Both Medicare and Medicaid are now seeking to contract out to HMOs and other private insurers the responsibility for designing efficient ways of delivering and paying for health services. Moreover, the experience of both these programs in the United States and the nationalized health systems in Canada and the United Kingdom is that individuals who have heterogeneous preferences for medical care are dissatisfied with the uniformity of a monolithic nationalized plan. A significant minority of British individuals buy supplemental private insurance (though such purchases are prohibited in Canada), and a majority of Medicare recipients buy Medigap policies.

On t-he surface, these nationalized schemes appear to be successful at controlling the growth of health care expenditures. However, the real social costs of these nationalized health plans are severely understated because the reported dollar expenditure figures do not reflect the time costs of patients and the forgone utility from unsatisfied demand that results from controlling costs by rationing, as Medicare and Medicaid are now doing. Nor do they reflect the tax-induced distortions of raising tax revenues to finance a nationalized plan.

Employer mandates. The more relevant comparison for our plan is the second prototype approach, of which the fundamental building block is a mandate that employers provide coverage to all employees and their dependents. Variants of this approach include the Minimum Health Benefits for All Workers Act introduced in Congress several times by Sen. Edward Kennedy (D-MA) and others; the Sen. John Rockefeller/Pepper Commission proposal, "Access to Health Care and Long-Term Care for All Americans;" the Massachusetts plan enacted in 1987 but so far not implemented; and the Alain Enthoven/Richard Kronick proposal. Advocates of these approaches claim that most uninsured people could be covered with no explicit additional government expenditure and without disturbing existing insurance arrangements for the majority of the population. Again, these advantages are overstated, and there are real disadvantages.

First, employer mandates typically exclude part-time workers; the Kennedy bill applies only to workers who work at least 17.5 hours a week and could cover at most two-thirds of the uninsured population.[3] But this assumes no changes in employment, whereas in practice there could be substantial changes in employment, either because money wages do not immediately fall sufficiently to offset the cost of insurance, because employers substitute more workers employed for just less than the

minimum covered hours, or because employers elect to employ fewer workers. If the mandate were limited to full-time employees (thirty-five or more hours per week) and their dependents, at most 54 percent of the uninsured would be covered, assuming no change in employment. An exemption for establishments with fewer than ten employees would leave 60 percent of the uninsured uncovered. Thus, an employer mandate alone cannot achieve universal coverage. Cumbersome supplemental insurance mechanisms become necessary, with supplemental sources of financing.

Second, the financing of an employer mandate is regressive; it is similar to a lump-sum or poll tax but with net tax rates that actually are inversely related to income, because of the tax subsidy. Third, employer mandate proposals usually leave in place the current system of open-ended tax subsidy for employer contributions to health insurance, which, as we and others have argued, is inequitable and leads to excessive health insurance coverage and use of medical care beyond the level that is justified by cost. And fourth, although most persons are likely to choose the employment relationship as the basis for buying health insurance, there seems to be no reason to favor this arrangement or to require it for all.

Indeed, proposals that add a supplementary scheme to cover those who would not be covered by an employer mandate typically offer higher subsidies under this scheme. For example, under the Enthoven/Kronick proposal, individuals not covered by employment-based insurance would be eligible for subsidized coverage through a public sponsor. This large subsidy is presumably motivated by the desire to achieve near-universal coverage without mandating it. This subsidy scheme also introduces a horizontal inequity between the employed and those not employed, at the same level of income.

Some proposals (such as the Rockefeller/Pepper Commission's) would establish tax credits/subsidies to certain small businesses to encourage them to provide coverage, while limiting the mandate to firms of over 100 employees. Using a subsidy to induce coverage is inefficient because the subsidy rate required to attract some will be more than enough to attract others, resulting in waste of tax dollars. Moreover, in the case of a subsidy targeted at small businesses, there is the added objection that tax subsidies should be targeted at those in need, and it is by no means true that all employers or employees in small firms have low incomes.

By contrast, our plan places the ultimate obligation for coverage on the individual rather than on the employer, with a uniform system of tax subsidies that depends only on the individual family's income, risk level, and cost of coverage, not on employment status. It thereby achieves universal coverage, eliminates horizontal inequities and incentive distortions between the employed and the unemployed, establishes a system of

financing that is progressive rather than regressive, and closes the current inflationary tax loophole. It offers neutral incentives to individuals concerning the choice between employment, group, and individual insurance. It protects the low-income working uninsured from the unaffordable expense of having to pay for "employer-provided" coverage through a wage offset. It uses the established insurance industry, under contract with the government, to provide fallback insurance.

The Enthoven/Kronick proposal establishes a new system of state agencies or "sponsors" that would contract with private insurers for coverage of individuals not covered through employment, verify income, collect revenues, implement a system of subsidies by income and health status, and manage enrollment. We believe that it is unnecessary and wasteful to establish a new bureaucracy to verify income and administer income-related subsidies. We also believe that the current adverse and preferred risk selection problems of private insurance markets will be greatly reduced when basic coverage is made mandatory and individuals are given financial assistance that is related to their ability to pay and the cost of their coverage. With these fundamental reforms, the residual problems probably can be handled at reasonable administrative cost.

Our scheme also involves less government intrusion and distortion than would be present in the strategy suggested by the Heritage Foundation.[4] They propose, in addition to putting some insurance obligation on individuals, using open-ended tax credits for both insurance premiums and out-of-pocket payments. The open-ended credit, which matches the consumer's expenditure at some percentage rate, is as inappropriate as the current tax subsidy. Moreover, the plan envisions a higher percentage matching rate to favor out-of-pocket medical expenses over insurance coverage. The intent is to "encourage consumers to purchase routine services out-of-pocket," and presumably would impose the administrative burden of reporting and monitoring of those expenses. In contrast, our approach provides a fixed-dollar tax credit, leaving consumers to make choices between insurance coverage and out-of-pocket payments above the minimum required coverage, based on a "neutral,, consideration of the true cost of each option.

Heritage's discussion also encourages "workers to purchase medical care and health insurance on their own," rather than through employment-related group insurance. The treatment of how this bias against group coverage would be accomplished is not very detailed, but it is suggested that there be "legislation requiring employers to distribute among their employees the money they now spend on health insurance." Our proposal does not intrude into the employer/employee wage determination process and permits the use of employment-related group insurance by firms that

expect that strategy to be attractive in the labor market.

Costs Of Providing Coverage

The main component of total gross cost of universal coverage is simply the number of uninsured (roughly thirty-seven million) times the per capita cost of coverage (roughly $1,200), or $44.4 billion. This overstates the net new cost because the uninsured already consume on average about 60 percent as much medical care as the insured. Thus the component of net new social cost that represents additional medical care for the uninsured, plus minimum insurance overhead, is approximately $17 billion.[5]

Three real issues differentiate the alternative national health insurance proposals. First, how great will be the additional dead-weight costs of distortions in labor markets and administrative overhead costs? Second, how will the cost of the new expenditures be allocated between private expenditures and general tax revenues? Third, will the new system build in incentives to eliminate waste and inefficiency in the health care system? We have already explained why we believe that our proposal scores highest in terms of minimizing dead-weight costs, equity of financing, and eliminating distorted incentives in the current system.

The political debate tends to focus on one part of the second issue: the visible cost to the federal budget. Our proposal is quite flexible on this point. The federal cost will depend critically on how high the level of tax credits is set for middle- and upper-income individuals. The current tax loophole for employer contributions costs $50–$60 billion.[6] Assuming that two-thirds of the currently uninsured (twenty-four million individuals) have incomes below twice the federal poverty line, if the cost of their coverage were paid in full, this would cost roughly $29 billion. Thus the poor and near-poor uninsured could be fully covered if subsidies to the currently insured were on average cut in half. Of course, our proposal would also pay new subsidies to low-income people who are currently insured, which would substantially increase the budgetary cost. We have already described the graduated scheme of tax credits we propose. The purpose of this numerical example is simply to point out, first, that the total budget cost depends on the level of tax credits selected, and second, that a substantial part of any new costs could be financed by closing the existing tax loophole and limiting the tax subsidies paid to middle- and upper-income individuals. Estimates of the net cost of prototype versions of our proposal should be made. We are confident that they would show a net budgetary cost less than that of the Rockefeller/Pepper Commission or of many other proposals.

Conclusion

The approach to national health insurance we have outlined has emphasized responsible choice at several levels. It emphasizes the responsibility of all Americans to obtain insurance, and of nonpoor citizens to pay for medical care services to the extent of their ability to do so. It emphasizes as well the responsibility consumers have to choose whether they want to buy more comprehensive medical care and medical insurance or whether they want to save more to spend on other goods. It emphasizes the responsibility of government in providing resources for low-income people to help them pay for the care and coverage they need, especially when their health risk is unusually high. It emphasizes the responsibility of the tax system to offer undistorted choices among insurance options, and to close tax loopholes that subsidize generous health insurance for the well-to-do. And it gives the government an alternative to the tempting but misguided approach of mandated benefits.

Exercise of these responsibilities provides a substantial benefit. It gives all citizens the opportunity for maximum informed choice. Our plan does not offer any magic way of cutting costs, any sure-fire scheme to deliver more for less, any easy way for employer benefits managers to pass the buck for rationing medical care, or any dream tax to allow politicians to finance medical services in an off-budget way. It does allow the greatest scope for consumers, within a competitive health care market, to compare the true costs and benefits of medical care, health insurance, and medical care plans, and then to make the choices that will benefit them most.

NOTES

1. The notion that ideal national health insurance should take the form of income-related catastrophic coverage has been advocated by health economists for twenty years. See M. Feldstein, "A New Approach to National Health Insurance," *The Public Interest* (Spring 1971): 93–105; and M. Pauly, *An Analysis of National Health Insurance Proposals* (Washington, D.C.: American Enterprise Institute, 1971).
2. A. Enthoven and R. Kronick, "A Consumer-Choice Health Plan for the 1990s." *The New England Journal of Medicine* 320, no. 1 and no. 2 (1989).
3. A.C. Monheit and P.F. Short, "Mandating Health Coverage for Working Americans," *Health Affairs* (Winter 1989): 22–38.
4. S. Butler and E. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989).
5. For more precise estimates, see P.M. Danzon and EA. Sloan, "Covering the Uninsured: How Much Would It Cost?" (Leonard Davis Institute Working Paper no. 9, December 1986).
6. U.S. Department of the Treasury, *Financing Health and Long-Term Care, Report to the President and the Congress,* 30 March 1990.