ANEW PROPOSAL TO
REFORM THE TAX
TREATMENT OF HEALTH
INSURANCE

by Alain C. Enthoven

Prologue: For the better part of a decade, Prof. Alain Enthoven of the Stanford University Graduate School of Business has been at the forefront of a growing movement to infuse the delivery of medical care with a structured form of price competition. Enthoven, an economist by academic training, has provided the intellectual lifeblood to this movement, educating a cadre of students who increasingly are finding their way into positions of influence, and impacting on the thinking of policymakers like former House Ways and Means Chairman Al Ullman (D-Ore.), Sen. David Durenberger (R-Minn.), Rep. Richard A. Gephardt (D-Mo.), and former Rep. David Stockman (R-Mich.). Enthoven, who set out his beliefs in a book entitled Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care, published in 1980, has been steadfast in his belief that the most appropriate remedy is not more bureaucratic controls imposed on, as he characterized it, “an inherently irrational system,” but rather fundamental reform of the financing and delivery system itself. As he explained in his book, “. . . we need to change from today’s system dominated by cost-increasing incentives to a system in which providers are rewarded for finding ways to give better care at less cost.” Enthoven believes that government’s role in this regard is not reorganization of the health care system by direct controls — as advocated recently in a presidential campaign speech by Democrat Walter E Mondale — but changing the tax laws and Medicare and Medicaid laws that create the underlying incentives. Enthoven, a member of the Institute of Medicine of the National Academy of Sciences, was assistant secretary of defense under former Secretary Robert McNamara and has also served as president of Litton Medical Products.
The present favorable tax treatment of employer contributions to employee health benefits costs federal and state governments a large amount in foregone tax revenues—about $30 billion in 1983. While tax incentives to purchase health insurance are desirable, there are four major problems with the present way the tax incentives are provided. First, it reinforces the cost-increasing incentives in our health care financing system and weakens consumer cost consciousness. Second, the distribution of the tax subsidies to health insurance is regressive. The present system provides substantial benefits for upper-income employed people, much less for low-income employees, and little or nothing for many self-employed, unemployed, and working poor. Third, the revenue loss to the government is growing much faster than the Gross National Product (GNP), thus contributing to the growing deficit. And fourth, the present system unnecessarily reinforces the link between jobs and health insurance.

In recent years, several congressional leaders have proposed a limit on tax-free employer contributions to employee health insurance and health benefits. The list includes Senator David Durenberger and Congressmen Richard Gephardt, James Jones, David Stockman, and Al Ullman. In 1983, the Reagan administration proposed a limit of $175 per month for family coverage and $70 per month for individual coverage, beginning in January 1984. This limit would be increased annually in proportion to the Consumer Price Index (CPI).

The enactment of such a tax cap would be an important step in the right direction. It deserves support on its own merits. But there is an even better way to reform the tax treatment of health insurance, one that more effectively addresses all of the major defects of the present system: that is to replace the present exclusion of employer contributions from the taxable incomes of employees with a refundable tax credit. This tax credit would be equal to 40 percent of each taxpayer’s health insurance premium payments to a qualified health care financing and delivery plan up to a limit on tax-subsidized premiums of $150 per family or $60 per individual in 1983 dollars. (This would be approximately the same as the Reagan administration’s proposed limit expressed in 1984 dollars.) A qualified plan would have to meet certain federal standards which will be discussed later in this paper.

This refundable tax credit would be available to all legal residents regardless of job status or employer contribution. The limit should be increased annually in proportion to GNP per capita in order to stabilize the government’s revenue loss as a share of GNP. This would replace a large and growing revenue loss that is tied to what amounts to open-ended entitlements in the private sector with a finite sum tied to the

The author gratefully acknowledges the advice and criticisms of an earlier draft by Victor Fuchs, Paul Ginsburg, Nancy Osher, and Amy Taylor.
The favorable tax treatment of employer-provided health insurance has had the very beneficial effect of motivating the rapid growth of private insurance coverage. In 1950, seventy-seven million Americans, or half the population, had some insurance against at least hospital expense. By 1980, the number had increased to 189 million or 85 percent of the population. Data from the National Health Care Expenditures Study indicated that by 1977, 88.3 percent of employees in the United States worked for employers that offered health insurance plans. And the scope and depth of coverage of these plans have increased greatly.

The Present Tax Treatment Of Health Insurance

The Internal Revenue Code of 1954 excluded employer contributions to the health insurance and health care of employees from the incomes of employees subject to federal income and payroll taxes. The states with personal income taxes have done the same. It is a safe bet that in 1954 nobody had any idea that Congress was enacting what twenty years later would become the second largest and one of the fastest growing federal health insurance programs. In FY 1975, according to Congressional Budget Office (CBO) estimates, the exclusion cost the federal budget $6.9 billion; by 1983 it was $25.7 billion. These amounts and their growth are compared with Medicare and Medicaid in Exhibit 1. In addition, Amy Taylor and Gail Wilensky estimated that in 1983 the exclusion cost states $3.8 billion in lost tax revenue. CBO has projected that by FY 1987, the loss to the federal budget will be $45.8 billion.

Exhibit 1
Growth In Federal Outlays And Tax Subsidies For Selected Health Insurance Programs (Billions of Dollars)

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<td>Medicare (a)</td>
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<td>Federal Medicaid (a)</td>
<td>6.8</td>
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<td>Exclusion (b)</td>
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A purely voluntary system of health insurance, based on individual decisions as to whether and how much to insure, would not produce results that would be acceptable in our society. In the absence of either compulsory health insurance or, what is almost the same thing, powerful financial incentives provided by government for people to buy insurance, the possibility of widespread health insurance would be destroyed by the process of adverse risk selection. Most medical care is elective with respect to timing. And individuals have private information about their health status and prospective health care needs that could be available to insurers only at very great cost, if at all. In a health insurance market made up solely of individual purchasers, and in the absence of powerful incentives for the healthy to purchase insurance (such as the tax subsidy in the exclusion), many individuals who expected no medical costs would either not insure at all or buy only insurance with very high deductibles and low premiums. Only those expecting medical expenses would buy insurance with low deductibles. When the well got sick, they would attempt to buy insurance. However, many would be unable to purchase insurance because insurers would exclude coverage for care of preexisting medical conditions. Premiums would be driven up to prohibitive levels, and insurance would become unavailable to many. Indeed, today the uninsured are heavily concentrated among those who do not belong to an employee group. This process would be exacerbated in our society by what economists call “the free-rider problem.” Many people who expected no medical costs would not buy insurance and, instead, would plan to fall back on the public sector for care if they became seriously ill.

We could deal with these problems by a system of compulsory universal insurance financed directly by government, as in Canada or the United Kingdom. But in our country, we have chosen to deal with these problems, in the case of those who are neither aged nor poor, by a system of tax subsidies for the purchase of private health insurance, the effect of which makes it attractive for the healthy to insure. Thus, the issue is not the need for some form of tax subsidy. The issues are its form and distribution. It would be a serious mistake to propose the elimination of all tax subsidies for health insurance.

**Defects In The Present Form Of Tax Subsidy**

In its present form, the tax subsidy for health insurance has several serious defects. First, the present system reinforces the cost-increasing incentives in the health care financing and delivery system. In a group of average taxpayers, if the employer were to increase pay by $100 per year, about $40 would go to federal income and payroll taxes and state income taxes. If instead the employer were to raise the health benefits contribution by $100 per employee, the full $100 would go to health benefits.
The typical response is for employers and employees to agree that the employer will pay most or all of the employee’s health insurance premiums with pretax dollars rather than paying the employee the equivalent amount in cash and leaving the employee to pay the premiums with net after-tax dollars. The incentive is also to cover very comprehensive benefits, including, for example, routine dental expenses, in the insurance plan so that even routine expenses will be paid with pretax dollars. For example, the number of persons covered by dental expense insurance increased from about twelve million in 1970 to over eighty million in 1980. Amy Taylor and Gail Wilensky have estimated that “employers pay 100 percent of the premium for almost half of the subscribers.” The consequence has been to destroy the cost consciousness of the individual employee in medical purchasing decisions.

During the 1970s, as this process took place, more and more employers became committed to 100 percent payment of the cost of a comprehensive fee-for-service, free-choice-of-doctor insurance plan. As economical health maintenance organizations (HMOs) with lower premium costs than their traditional insurance competitors grew and became more widely available, it might have seemed rational for employers to peg their contributions to the cost of membership in an HMO, and to let the employees who wanted to do so pay the extra cost of the most costly plan themselves. However, only a minority of employers have done this. Most employers have been exceedingly reluctant to go back on a previously granted “entitlement.” As a consequence, employees in such groups have little or no financial incentive to join an economical HMO.

Health insurance benefits have provided union leaders with a generous supply of bargaining prizes. Perhaps the union members who are less schooled in economic reasoning actually believe that it is the employer who is paying for these benefits, rather than employees in the form of reduced wages. On the other hand, those who are more schooled in economics probably recognize that health benefits are paid out of what would otherwise be wages, but they also recognize the large tax subsidy. Thus, the open-ended tax exclusion has given union leaders an additional and powerful incentive to bargain for 100 percent employer payment of a comprehensive package of benefits.

A new approach is needed to encourage employers and unions to reconsider these patterns of behavior. A change in the tax laws that limits the amount of employer contribution that could be tax free to the employee would help.

The second major problem with the exclusion in its present form is that it is regressive, and that it treats people of similar incomes and health insurance purchases differently merely by virtue of employment status. Paul Ginsburg estimated that in 1983 the exclusion was worth $83 or .65 percent of income for households with incomes from $10,000 to $15,000,
but $622 or .98 percent of income for households with incomes between $50,000 and $100,000. Part of the reason for this is that employer contributions are larger for the higher-paid group: an average of $2,025 versus $972 for households in these income categories receiving employer contributions. Employers of higher-income employees are much more likely to make contributions: 73 percent of households versus 31 percent for the two groups. Part of the reason for this difference is that exclusions are worth more per dollar to people in higher tax brackets. Not only does this distribution of federal health insurance subsidies across the income classes seem inappropriate, but also there are “horizontal inequities.” The present form of the exclusion does nothing for the self-employed or many other people who need and buy health insurance but do not have an employer contribution.

Of course, any tax deduction or exclusion will be more valuable to upper-income people because they pay taxes at higher rates. And one cannot make a fair appraisal of the equity of a particular provision of the tax code without considering the impact of the code in its entirety.

But, in effect, the tax exclusion has become a health insurance program, and it needs to be considered from the point of view of society’s values concerning access to health care. It appears that we have a national consensus that everyone should have financial access to good quality health care and to health insurance at reasonable rates. Congress has expressed that in enactment of Medicare and Medicaid, other programs for special groups, continuation of the tax subsidy for the employed, and in attempts to pass health insurance programs for the unemployed. Nobody defends gaps in health insurance coverage. Yet, the present form of the tax subsidy encourages upper-income employed people to buy more health insurance while failing to help many who need it most, such as intermittently employed and self-employed persons. The irony is compounded by the fact that many low-income people without health insurance fall back on the public sector when seriously ill so that the taxpayers pay for their care anyway. It would make more sense to facilitate their purchase of private insurance in order to help them not become a burden on the public sector.

As noted earlier, a free unsubsidized market of health insurance for individuals breaks down because of adverse risk selection. To counteract this, a powerful financial incentive is needed to encourage the healthy to insure. Such an incentive is available to employed people. What rational basis can there be for denying the same benefit to those who are not employed?

The third major defect in the present form of the tax subsidy for health insurance is that the revenue loss to the federal government, already large, is growing much faster than the GNP. Paul Ginsburg estimated that the federal revenue loss increased from $3.2 billion, or .34 percent
of GNP in FY 1970, to $19.8 billion, or .7 percent of GNP in FY 1981. This growth in relation to GNP has occurred for several reasons. First, health spending has grown faster than GNP, for example, from 7.5 percent of GNP in 1970 to 9.8 percent in 1981. Second, there have been marked increases in the scope of private health insurance. For instance, in 1970, as noted earlier, about twelve million persons had insurance for dental expense. By 1980, the number exceeded eighty million. And third, payroll tax rates have increased, and effective marginal income tax rates have increased as people were pushed into higher marginal tax brackets both by inflation and gains in real income. While the reduction in tax rates and the indexing of the tax brackets in the Economic Recovery Tax Act of 1981 (ERTA) will presumably stop the “bracket creep” associated with inflation, the other factors, including already-legislated future increases in payroll tax rates, will continue to increase the revenue loss if no corrective action is taken. In the future, this will become a more serious problem for the federal government than it has been in the past because ERTA deprived it of inflation-induced “bracket creep” as a source of revenue growth. ERTA will limit the growth in federal income tax revenue as a share of GNP to that which comes from growth in real per capita income.

The growth in this source of revenue loss is likely to be exacerbated by provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Social Security Amendments of 1983. In that legislation, Congress limited the growth in the amount per Medicare inpatient case that Medicare will pay to “market basket plus one percent,” at least through 1985. At the same time, some states are engaging in selective contracting with hospitals at negotiated rates for Medicaid cases. If employers continue to make open-ended payments for fee-for-service medical care and for hospital charges on a non-negotiated, free-choice-of-provider basis, hospitals are likely to try to shift costs not paid by Medicare and Medicaid onto private payers. In that event, if government does not limit its tax subsidy to employer-provided health insurance, it is likely to end up paying 40 percent of the shifted costs through tax revenue losses. Government will become the main victim of the cost shift!

Finally, the present form of the exclusion reinforces the link between jobs and health insurance. This link adds greatly to the complexity of the health insurance market. For example, many people lose their health insurance when they lose their jobs. Those who work for an employer who self-insures or who buys an experience-rated policy from an insurance company are not likely to be able to continue their health insurance at their own expense, or if they are, it will not be at anything close to the group rate. HMO members who leave their employment group can continue their membership by continuing on their own to pay the community rate. But if an HMO member changes jobs and switches to an employer
who does not offer the HMO to his employees, the member is likely to be forced to change HMO and, probably, change doctors. A different form of the tax subsidy could ameliorate these problems considerably.

If one counts the tax subsidies, government is now paying about half the total cost of health care services. Yet we still do not have universal health insurance. Millions of people who do not belong to employment groups are denied the opportunity to buy health insurance and denied the subsidies available to employed people if they are able to buy insurance. Think of the problems of a widow or divorcée in less than perfect health who depended on her husband’s employment group for health insurance. She is likely to become uninsurable or at least have coverage that excludes treatment for pre-existing medical conditions. In addition, she is denied a tax subsidy for health insurance. Can anyone put forward a rational defense of such a state of affairs? The plain fact is that our present system is an historical accident that is very hard to change because large numbers of influential people have a vested interest in the status quo. Congressional efforts to extend health insurance to the unemployed have failed, mainly because of budgetary problems, but also because of the problems of complexity of job-related health insurance and the lack of subsidies to support health insurance for unemployed people. We ought to be moving in the direction of universal health insurance, at least in the minimal sense of assuring each person the opportunity to buy health insurance at approximately a group rate.

The Proposed Reform

Congress ought to go beyond the tax cap and provide that every resident may receive a refundable tax credit equal to 40 percent of his or her own or the employer’s health insurance premium payments to a health insurance plan meeting federal standards, up to a limit on subsidized premiums such as $150 per family or $60 per individual per month, in 1983 dollars. This would entirely replace the present exclusion. Employer payments would be included in the taxable income of the employee reports on Form W-2. A line would be added to the tax credit section of Form 1040. To substantiate the credit, the taxpayer would staple to the form a “Form H-2,” a receipt from a qualified health plan. A “refundable tax credit” means that the taxpayer’s liability is reduced by the amount of the credit, and in the event that the taxpayer’s liability not counting the credit is less than the credit, the difference is refunded to the taxpayer in cash.

The credit would not be available to beneficiaries of Medicare and Medicaid. For persons covered by those programs for part of the year, the tax credit would be available for the months during which they were not covered by those programs. The tax treatment of employer-paid
health benefits for retired Medicare beneficiaries would not be changed by this proposal, but it should be reviewed and considered in its relationship to the Medicare program.

The limit would be increased each year in proportion to GNP per capita in order to adjust for inflation and to stabilize the cost to the government as a share of GNP. Since GNP per capita goes up faster than inflation, this allows for inflation plus an additional amount to help offset the effects of an aging population and advancing technology. (More precisely, the limit should be increased each year in the same percentage as the average change in GNP per capita over the past five years, in order to smooth out fluctuations.)

Reasons For The Proposal

First, this proposal would give everyone—including the healthy—a strong incentive to insure up to the limit, but a disincentive to buy a health insurance plan costing more than the limit. Those who bought less than the limit would be walking away from a subsidy. A family that did not insure would be turning down a $60-per-month subsidy (40 percent of $150). This incentive would be likely to attenuate the problem of adverse risk selection, described earlier, that makes it so hard to make health insurance available to individuals not part of an employment group, by giving healthy people an incentive to keep their insurance. However, it is not possible to predict, with presently available data, how effective this incentive would be. At the same time, this proposal would make every purchaser cost-conscious in the choice of health care plan, and liable for the full premium cost above the subsidized limit. Families considering health plan alternatives with costs at or above the limit would be able to keep for themselves the full savings generated by the decision to choose the less costly alternative. Thus, enactment of this proposal would expand the demand for membership in cost-effective health care financing and delivery plans.

Second, this proposal would equalize the subsidy for health insurance across the income classes. The subsidy and the incentive to insure would become the same for high-income and low-income families. (Additional subsidies would be desirable for low-income families, but that issue could be considered separately and perhaps at the level of state and local government.) This proposal would treat equally two taxpayers with the same income and health plan, one of whom happens to have an employer while the other is self-employed. This proposal would also give the unemployed the opportunity to keep the health insurance they had when they were employed.

Third, this proposal would replace what amounts to an unlimited federal subsidy of privately negotiated open-ended entitlements with
fixed-dollar subsidies that would grow at the same rate as the GNP. Thus, it would help to balance the budget in the long run.

Why should the limit be around $150 per family per month in 1983 or $175 in 1984? The idea is to provide every family an incentive to subscribe to a good quality comprehensive but economical health care financing and delivery plan. Ideally, from a health insurance point of view, if we were dealing with a single market, the limit would be set at the price of the least costly comprehensive health care financing and delivery plan. That would assure everyone subsidized access to comprehensive care. However, there are other factors to consider including regional variations and political judgments about support and priorities. For 1984, $175 was the Reagan administration’s choice: A similar approach would be that used in Sen. David Durenberger’s Health Incentives Reform Act of 1979: a limit equal to the average premium cost for federally-qualified HMOs. That stood at about $172 per family per month in mid-1983, which, when adjusted for inflation, would yield a somewhat higher figure for 1984. However, there is no compelling reason why the limit must match 100 percent of the average HMO premium.

Why make the credit 40 percent of the limit? This is a judgment call reflecting several factors. First, 40 percent is approximately the average marginal tax rate, including both income and payroll taxes. Thus, the position of the average taxpayer belonging to a 100 percent employer-paid plan with a premium at the limit would be unchanged. Lower income people would gain, above-average-income people would lose. Second, a substantial subsidy, about that large in my judgment, would be needed to motivate most healthy people to buy fairly comprehensive insurance plans, and thus combat the adverse risk selection problem described earlier. If cost and budgetary considerations rule this out, Congress might try a lower percent as an alternative. Somewhere not far below 40 percent, a “budget neutral” proposal could be designed.

Why should the tax credit be refundable? The purpose of the proposal is to encourage low-income people to insure even if they have little or no tax liability. The limit should be applied to the tax-paying unit—the individual or couple filing a joint return—and not to the employer. There are millions of two-earner households, even millions of two-job people. As a result, roughly fifty million people have duplicate coverage which is costly and can defeat the cost-reducing incentive effects of coinsurance. Some people collect duplicate insurance payments and don’t pay tax on them. A family doesn’t need two $150-per-month tax shelters; one per family is enough.

Should there be regional adjustments to reflect differences in factor costs? This is essentially a political question. The proposal ought to be enacted with or without regional adjustments for factor costs. Regional adjustments have often been proposed and debated. One reason for
them is to prevent hardships for people in high-cost areas, and windfalls for people in low-cost areas. Another is to give recognition to the fact that, at equal tax rates, people in higher wage areas pay higher taxes. On the other side, there is no precedent for regional adjustments in the tax laws. To create regional adjustments in the tax credit, it is argued, would open Pandora’s Box and unleash a free-for-all scramble for all sorts of regional preferences. Another argument for uniformity is that regional variation would add to complexity of administration. However, it would not need to be more complicated than a table of limits by state in the tax-return instructions. Finally, one could argue that the uniform limit hits hardest where needed most, in the high-cost areas.

In the new Medicare system of prospective payment to hospitals by diagnosis-related group (DRG), regional hospital wage differentials are recognized and will be allowed to persist. Personally, I would prefer to see Congress define the tax credit as a health insurance program and allow regional variations for factor costs. But I do not think the value of this proposal depends critically on that provision.

Why index the limit to GNP per capita? The overall CPI has been criticized as overly sensitive to such factors as the impact of interest rates on housing costs. The trouble with using the medical care component of the CPI is that this would help reinforce the inflationary cycle. The use of GNP per capita instead of the GNP deflator recognizes that such factors as advancing technology and an aging population create valid reasons for increasing real per capita spending, and that stabilizing health care spending as a share of GNP is a sufficiently ambitious goal, Congress could review this periodically in relation to other priorities.

**Additional Reforms That Could Be Tied To Tax Credits**

While the change in the tax treatment of health insurance could stand on its own merits, I would recommend tying it to some other changes intended to promote universality and continuity of coverage and to facilitate competition among health plans. In order for premium payments to be eligible for the refundable tax credit, health care financing and delivery plans should have to meet certain standards.

First, a qualified plan should be required to offer people who leave an employment group the right to purchase the same coverage at their own expense at rates not to exceed, for example, 110 percent of the group rate, the excess to cover extra administrative costs. The same right should be available to dependents who lost coverage because of death or loss of employment of the employee, divorce from the employee, or loss of dependent status because of age or graduation from college. This right should be exercisable without medical review or exclusion of coverage for pre-existing medical conditions. (The employer’s obligation could be...
cancelled by the employee’s joining another employee group offering a qualified health insurance plan.) Self-insured employers could discharge this obligation by providing the coverage themselves or by contracting for it with an insurance carrier. I recognize that such a requirement is not without cost to employers. But continuity of coverage is an important social purpose that government would be paying to achieve by the tax subsidy.

The main argument against such a requirement is that the per capita costs of insuring people who leave an employment group are quickly driven up by adverse risk selection. People who lose their jobs and don’t expect any medical needs drop their health insurance, while those expecting to need medical care keep theirs. One of the purposes of the proposed tax credit is to attenuate this process of adverse risk selection by giving healthy people an incentive to continue their insurance. If necessary, Congress could compromise the implementation of this principle by enacting a time limit such as a year.

Additional measures would be required to assure universal availability of health insurance. But continued subsidies to people leaving employment groups and continuation of their right to buy insurance at approximately the group rates would be a major step in the right direction. Congress and/or state legislatures might consider a subsequent step of contracting with HMOs and insurers to offer insurance to persons not eligible for group coverage, while subsidizing the excess risk component of the cost of such coverage. (That is, insuring people who are not members of a group costs more than insuring a group of similar age-sex composition because of the adverse risk selection associated with individual coverage. Estimates of this excess risk component can be made by reference to the average cost of insuring group members. A government agency could negotiate to pay a subsidy to a health plan to induce it to offer coverage to individuals at group rates.)

It is worth noting that HMOs presently allow members who leave their employment group to continue their coverage at their own expense at the community rate. Because I belong to an HMO, my child can purchase individual coverage at the community rate without medical review or exclusions for pre-existing medical conditions when he or she ceases to be my dependent. The same would be true of my widow in the event of my death. Congress should require that whatever health insurance contribution an employer makes should be equally available to a new employee who wishes to retain membership in his HMO, whether or not the employer offers coverage by that HMO.

Continuity of coverage standards should include the requirement that coverage for dependent children begins automatically at the time of birth or adoption, and that employer group plans contain no exclusions or restrictions on coverage based on pre-existing medical conditions. Exclu-
sion of coverage of care for pre-existing medical conditions is a means that health insurance companies use to protect themselves from medical costs of chronically ill people and from "the free-rider problem," in which people do not buy health insurance until they become sick. While understandable from an individual company point of view, this practice is indefensible from a social point of view. It means denying health insurance to the people who need it most. If there were a general ban on exclusion of care for pre-existing conditions, individual companies would not need to suffer a worsened competitive position by dropping such exclusions. Similar continuity of coverage provisions were included in Sen. David Durenberger's Health Incentives Reform Act, first introduced in 1979.\textsuperscript{15}

Next, every qualified plan should be required to meet at least a common standard of services covered and limits on out-of-pocket payments. The standards defined by the HMO Act of 1973 would be a good point of reference. However, many people would feel that the HMO Act and regulations define a coverage that is too costly and comprehensive. If Congress were to decide that this is the case, it could adopt a less costly standard. But to achieve a fair competitive market, all qualified health plans, including HMOs, should be required to meet the same standard. Because of the problem of risk selection in a competitive market, choice of benefit package has to be a social and not an individual decision. Health plans that wish to offer more extensive benefits may do so, but at their own risk of attracting an adverse selection of health risks attracted by the more generous benefits.

There are several reasons for requiring a common standard of coverage or "benefit package." The first is to prevent deceptive or inadequate coverage, "Swiss cheese" insurance policies with gaps in coverage that insureds only discover when they need health insurance. (An example would be coverage of newborns not beginning until ten days after birth.) The second is to discourage the use of the benefit package as a tool to select preferred risks. One insurance plan can always select better risks than another by offering a higher deductible and lower premium. Those consumers not expecting to need medical care will find it to their advantage to take the lower premium. Eventually, only health plans with very high deductibles would survive. Third, health insurance policies are very difficult to understand and compare. If left without controls, insurers can differentiate their policies in such a way as to make valid price comparisons very costly. A simple way to focus competition on price, quality, and accessibility of care and service is to standardize most of the fine print that most people can't understand and can't remember anyway.
The following estimates of costs and savings are based on 1983 levels of spending and assume a 1983 limit on subsidized premiums of $150 per month for a couple filing a joint return and $60 per month for an individual.

Several assumptions need to be specified. First, these estimates assume that the limit is applied to each taxpaying unit, as I have described above. Second, this proposal includes no change in the tax treatment of employer-paid insurance for Medicare beneficiaries and their supplemental policies. Third, Medicaid beneficiaries would be unaffected by this proposal. They would not receive tax credits in the months in which they are covered by Medicaid.

The gross cost of the tax credits in 1983 dollars, assuming the 1983 pattern of health insurance premium expenditures, would be $31.1 billion. If we assumed that every eligible person were to take full advantage of the credits—a state that would require at least several years to be reached—the gross cost in 1983 dollars would be $38.4 billion.

Offsetting these costs would be the increases in tax revenue realized by including all employer contributions in the taxable incomes of employees. The increased federal income tax revenues at 1983 levels would be $19.5 billion. The increase in federal payroll tax revenues would be $6.5 billion. Assuming all states with personal income taxes followed suit, increased state income tax receipts would be $3.8 billion. The federal government would need to negotiate with the states to recapture these savings by making offsetting reductions in grants to states. The estimated impact on the federal budget would depend on what one assumes about the action of Congress to recapture these revenues.

Combining these numbers, one can derive a “worst case” first-year estimate of the cost to the federal budget of $12.4 billion, that is $38.4 billion (assuming all eligible people take full advantage) less $26 billion (assuming Congress does not recapture the increased state income tax revenues). And similarly, on the opposite assumptions, one can derive a “best case” estimate of $1.3 billion, that is $31.1 billion less $29.8 billion.

I believe the “best case” is closer to the truth at the outset, because Congress could, in effect, recapture the increased revenues of the states by offsetting reductions in grants, and because it would take several years for all eligible people not now insured to find ways of obtaining health insurance. Moreover, under this proposal, the revenue loss from the present unlimited exclusion, which is growing at a rate that about doubles its share of GNP in a decade, would be replaced by a tax credit keyed to grow with the GNP. Thus, whatever net revenue loss there might be at the outset should be regarded as a modest investment to achieve important long-run savings.
And if Congress were still not satisfied with that, it could phase in the tax credit, starting with, perhaps, 35 percent instead of 40 percent of premium payments, or with a lower limit on the subsidized premiums. In other words, as noted earlier, a version of this proposal could be devised that would be “budget neutral” in the short run and cost saving in the long run.

Some Problems With The Proposal

As is the case with any proposed change in public policy, this one is not without its problems. First, what about high-risk groups, people who have high premium costs because they are older or in occupations that lead to high medical needs? A limit on the tax subsidy could penalize them unfairly. To solve this problem, it would be necessary to vary the subsidies by actuarial rating category and to require every health plan to practice community rating by actuarial category. I proposed this in Consumer Choice Health Plan. Community rating means charging the same premium for the same benefits regardless of the health status of the groups or individuals covered. Under a scheme of community rating by actuarial category, the population is divided into groups based on factors that predict medical need. Health plans can charge higher premiums for covering people in higher-risk categories. This compensates the health plan for serving people in higher-risk categories. These people, in turn, can be protected from the burden of higher costs by the government paying proportionately higher subsidies on their behalf. The best example of this idea in actual operation is the recently tested and enacted system under which Medicare pays HMOs for caring for its beneficiaries. Medicare will pay the HMO 95 percent of the Adjusted Average Per Capita Cost (AAPCC), which is the average cost to Medicare of similar persons who remain with fee-for-service, considering age, sex, location, institutional status, and other factors. Some kind of system to compensate health plans for serving higher-risk persons, while protecting the patients from the higher costs, is a necessary part of any system of fair economic competition of health care plans. It might be appropriate to begin with a simple stratification based on subscriber’s age, such as under/over forty-five, and eventually phase in a more refined system.

Next, there is the question of probable employer response. Under the “tax cap” proposal, I believe the most probable response of employers now contributing more than the limit would be to make fixed-dollar contributions to employee health insurance at the tax-free limit, and to pay the employees the rest of what they were contributing in cash. Under the “tax credit” proposal, employer payments for health insurance would be included in the employee’s taxable incomes. So employers might just as well pay the employees cash as health insurance contributions. Would
this destroy the employer incentive to organize health insurance for employees? Or would it cause employers to lose interest in what health insurance costs? I think not. Availability of good health insurance options would remain an attractive fringe benefit employers would want to offer to attract employees.

Next, there is the problem of windfall loss for those employees now receiving large employer contributions to costly health plans. Some auto workers, for example, are receiving employer contributions in excess of $300 per month. Under the tax credit proposal, an employee previously receiving $300 per month tax free would suffer a $720-per-year increase in tax liability (assuming he is in the 40 percent marginal bracket). Nobody should be subjected to a sudden large and disproportionate loss by a change in the tax laws. Usually Congress deals with this kind of problem by including “grandfather clauses” or transition rules. Such provisions would be appropriate in this case. For example, an employee might be allowed to retain an individual limit on tax-subsidized health insurance premiums equal in dollar amount to the employer’s contribution in 1983 until the increase in GNP per capita caught up to that amount. Of course, one must acknowledge that, to the extent individuals are protected from increased tax liabilities by transition rules, the initial net budgetary cost of the proposed tax credit will be higher.

One of the purposes of this proposal is to create market conditions more favorable to the growth of cost-effective comprehensive care organizations by making buyers cost conscious in their choice of health plan. Under the present “employer pays all” mode, there is often little or no incentive to make an economical choice. Some leaders of the HMO movement are concerned that the tax-subsidized amount might not keep up with the costs of a comprehensive plan. To see the potential problem, imagine that the subsidized limit were $50 per family per month rather than $150. Some insurers would then offer policies with a $50 monthly premium and a deductible high enough to make that possible. People expecting no medical costs would choose a high deductible. People expecting substantial medical expenses would choose comprehensive plans such as HMOs. HMOs would be destroyed by adverse selection. This is a matter of particular concern to HMOs because the federal HMO Act requires them to cover comprehensive benefits, but does not place similar requirements on other health insurance plans.

One answer to this concern is that tying the limit on the subsidized amount to the growth in GNP per capita should allow for continued real growth. Even so, if health care costs continue to rise much faster than GNP per capita, the medical purchasing power of the subsidized amount could erode. Congress should review the program periodically to prevent excessive erosion. Another safeguard would be the common benefit standard applied to all health care plans qualifying for the subsidy.
HMOs would then be subject to the same rules as their competitors and not forced to offer more comprehensive coverage.

What about administrative expense? Under the tax credit the IRS would see millions of new “H-2 forms.” A new line would be added to Form 1040 for a new tax credit in addition to the eight already there. Millions of people who do not now file tax returns would do so in order to receive their refundable tax credit. Employers who do not now allocate health insurance expenses on a per employee basis would have to do so. They would have to allocate on a per individual or family unit basis and by geographic area when there are significant differences. As an accounting problem, this would be no more complex than most. This cost needs to be judged in the context of the problem of rapidly rising health care costs, the gains in efficiency that could be achieved in a more cost-competitive health care economy, and the great complexity of regulatory solutions to health care cost problems. I believe the efficiency gains would far outweigh the costs of administering the tax credit. And I think it is inevitable that the federal government will have to act somehow to bring the growth in its revenue losses associated with tax subsidies to health insurance into line with the GNP.

Finally, some argue that limiting the exclusion is unnecessary because some employers are beginning to add coinsurance and deductibles and otherwise reduce previously granted open-ended entitlements. In the absence of a change in the tax laws, I doubt that this will be a very pronounced trend. Putting in a $250 deductible, for example, is not a very draconian cost-control measure. Other reports indicate strong resistance by unions to any cuts in health benefits. Absent a change in the tax laws, it is hard to see why employers and employees would find it in their interest to agree that the employee pay a greatly increased share of health care costs with net after-tax dollars. In any event, the proposed refundable tax credit also addresses other deficiencies in the present tax treatment of health insurance.

Conclusions

In sum, replacement of today’s open-ended exclusion of employer contributions from the taxable incomes of employees with a refundable tax credit equal to 40 percent of each individual or family’s premium payments to a qualified health care plan, up to a limit of 40 percent of $60 or $150 in 1983 dollars, would make subsidies for the purchase of health insurance universally available to those who could buy insurance. This would attenuate the adverse risk selection problem that now plagues attempts to cover individuals not in groups. Combined with continuity of coverage requirements for qualified health plans, this would facilitate continued coverage for the unemployed.
At the same time, the tax credit would make buyers cost conscious in their choice of health plan, and thus replace an important cost-increasing incentive with a reward for an economical choice. This would represent a major and favorable change in the health care economy from the point of view of demand for membership in cost-conscious health care plans. And the tax credit would distribute public subsidies for the purchase of health insurance more equally across the income classes and within income groups, as between the employed and others.

The tax credit approach would greatly reduce the “Medicaid notch” -the loss in public subsidy that a Medicaid beneficiary suffers when he or she increases his or her earnings enough to exceed the eligibility limit. The tax credit approach would also bring the growth of the federal revenue loss from tax subsidies to health insurance into line with the growth of the GNP. And the tax credit could be used as a lever for some socially desirable rules for fairer competition among tax-favored health care financing and delivery plans.
NOTES

2. Internal Revenue Code, sec. 105 and sec. 106.
8. Ginsburg, in Containing Medical Care Costs, estimates that in 1983, the average federal marginal tax rates that would apply to employer contributions if they were taxed was 38 percent.
11. Ginsburg, Containing Medical Care Costs.
12. Ginsburg, Containing Medical Care Costs.
15. Health Incentives Reform Act.
17. See Taylor and Wilensky, “The Effect of Tax Policies.” This calculation excludes the tax revenue loss associated with the exclusion of employer contributions to the health insurance of retired Medicare beneficiaries, estimated conservatively at $900 million.