Prologue: Long-term care is one of the forgotten stepchildren of American medicine. Unlike the government-dominated health systems of Canada, the United Kingdom, and other Western industrialized countries, which have integrated long-term care into the range of other offered services, long-term care in the United States is dealt with in a more piecemeal fashion. Complicating the issue is the broader conflict over the respective roles that the private and public sectors should assume over the long term in the American system of care. While the government has resisted addressing the issues of long-term care in any global fashion, total national expenditures for nursing home care have increased manyfold over the last decade. In 1984, nursing home expenditures totaled $32 billion, an increase of 11.1 percent over the previous year. Direct out-of-pocket payments are the source of almost half of total payments to nursing homes, a much higher percentage than for most other medical services. In this essay, William Anlyan, an attorney who was formerly assistant to the vice-president for health affairs at the University of Virginia and is now in private business, and Joseph Lipscomb, an economist on the faculty at Duke University, advance a proposal that addresses a host of issues, including long-term care, tax-exempt health insurance, and the private sector role. Their scheme, called the National Health Care Trust Plan, would restructure tax incentives that influence the purchase of private health insurance and personal savings decisions. Anlyan and Lipscomb point out, quite accurately unfortunately, that policy debates in recent years about cost control through medical market reform, on the one hand, and financing long-term care for the elderly, on the other, have proceeded independently. At the heart of their proposal is a strong belief that a potential link exists between these seemingly distinct areas of concern. The National Health Care Trust Plan is designed to address both of these problems in a way that has not been considered before.
Two Intertwining Dilemmas

Two seemingly distinct dilemmas have surfaced in the health policy debate at the moment: (1) How to sustain the ongoing public-private assault on medical costs while somehow preserving (perhaps even improving) access to care by the poor and underinsured, and (2) How to finance long-term care (LTC) over the long term for an aging population, in a way that minimizes damage to the economy and strengthens, rather than tears at, the social fabric. In response to these issues we introduce an incentive-based market reform strategy, termed the National Health Care Trust (NHCT) Plan.

The NHCT plan would restructure tax incentives influencing at once both private health insurance and personal saving decisions in ways that would stimulate fair competition in the medical marketplace as well as encourage stronger private sector efforts to finance long-term care for the elderly. Moreover, a fully implemented NHCT plan would include an income-based system of federal transfer payments to ensure that the medically indigent, broadly defined, had “decent minimum” access to medical care both now and in retirement.

In the near term, the NHCT plan would supplement and mesh logically with existing Social Security, Medicare, and private pension systems. But in the long run, a successful NHCT plan would effectively achieve a major evolutionary reform in the financing of medical care for the elderly. Gradually, we would move away from the current policy in which today’s workers are largely responsible, through Medicare-earmarked taxes, for the medical care of today’s elderly. Rather, the NHCT plan would provide the nonelderly with heightened incentives and opportunities to make financial provision over the life cycle for a major portion of the medical and social services they would consume during retirement. In our scheme, government would never abandon the elderly who fall financially destitute, but there should be a substantial reduction in the proportion who do become medically indigent. In addition, a fully functioning NHCT plan would diffuse—and perhaps send into permanent remission—the crisis over the long-term solvency of the Medicare trust fund. Likewise, it would serve to redefine the nature of that increasingly uneasy partnership through which many employers and the federal government jointly pay for the health care of the firms’ retirees.

Historically, the road to medical market reform has been paved with good detentions. Over the past fifteen years, many national health insurance proposals have emerged, some have been debated in Congress, and
none has become law. However, recent incentive-oriented approaches to medical market reform and cost control ought to fare better in Congress. Prototypically, for example, Alain Enthoven’s Consumer Choice Health Plan (CCHP), there is no call for the government to expand either its direct provision of services or its public insurance umbrella. Yet the prospects for a CCHP-like national health plan are far from certain. A consensus fear of widening the federal deficit is an immediate obstacle to reform, for even a streamlined version of CCHP that left Medicare and Medicaid untouched would increase expenditures some in the near term.

But the major challenge over the long haul is creating a coalition of health and social policy interests with enough unity and stamina to overcome Congress’s inclination for incremental policy making. The usual political difficulties of achieving broad reform are compounded here by the fact that business, labor, health insurers, and most provider groups all appear to object to significant aspects of such procompetition plans. We believe the National Health Care Trust Plan can stimulate competition through system changes that are more likely to be acceptable to these key private sector interests.

Dilemma 1: controlling cost and preserving access. U.S. medical expenditures increased at an average annual rate of nearly 14 percent over 1976-81 and at an all-time high annual rate of about 15.5 percent over the final two years of that period. In 1983, when the consumer price index (CPI) rose by 3.9 percent, its medical component increased 11 percent and medical expenditures overall jumped 12.5 percent. All the while, Medicare and Medicaid costs were generally growing at even faster rates.

Efforts such as the diagnosis-related group (DRG) system initiated in 1983, the growth of alternative providers such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs), and the development of more than 150 business/health coalitions since 1979 have had a moderating effect on health expenditures. However, medical costs represent a chronic problem; in 1984 the medical care component of the CPI rose 50 percent faster than the overall index (6.1 percent versus 4.0 percent), and medical expenditures increased nationally by 8.1 percent. Total employer non-Medicare spending on health care for persons aged sixty-five and over more than doubled between 1980 and 1984 (from $148 million to $308 million) and should exceed $5 billion by the decade’s end.

In addition, there are gaps in access to quality medical care for the nonaged. A widely reported 1982 analysis of the nation’s medically disadvantaged concluded that, despite Medicare and Medicaid, 28 million Americans—about 12 percent of the population—face significant financial barriers to basic medical care. Among those affected are nearly 14 million uninsured adults (plus their children). Davis and Rowland esti-
mate that 70 percent of Medicaid's 1984 expenditures of $50 billion went to the aged and disabled, while 60 percent of Americans below the poverty line remain ineligible for benefits.9

Dilemma 2: medical care for the elderly. Statistically speaking, Medicare and Medicaid are heavily implicated in the medical cost crisis. Together, they have significantly expanded access to care for the elderly and poor; in 1985, nearly 80 percent of all federal health outlays will flow to these two programs. Yet persons age sixty-five and over spent a higher fraction of their total personal income on medical care in 1980 than in 1970 (19.1 percent versus 16.8 percent).10

The major underlying factor exacerbating the plight of the elderly here is their increasing numbers relative to the working age population, whose taxes effectively pay for these programs. Between now and the year 2030, the fraction of Americans age sixty-five or over will grow from one in nine to one in five; the fraction over seventy-five (who are functionally the most dependent) will grow even faster.11 The ratio of workers to Medicare beneficiaries will fall from the current 3.1:4 to about 2.1:1.12 Even if budgetary maneuvers and increased cost sharing (which are already underway) can maintain the current size of the Medicare and Medicaid pie, it surely will have to be sliced into increasingly thin pieces in the decades ahead.

Should elderly shoulder more of the burden? Largely because they are inflation-adjusted, Social Security payments have increased dramatically in recent years (205 percent from 1968 to 1981 in nominal terms) and will stabilize soon at a point where the average retiree will receive monthly payments sufficient to replace 43 percent of life-cycle average income.13 In addition, about half of all workers now participate in private pension plans, whose average payout per retiree in 1980 was nearly $14,000.14 About 18 percent of all males and 8 percent of females aged sixty-five and over continue to work full-time or part-time.15

Have we not reached the point where the elderly can afford to pay for much more of their own non-Medicare health and social services? For items like eyeglasses, hearing aids, and prescription drugs, perhaps yes. But, half the nation's elderly still had income below $9,000 in 1981—an amount quickly consumed when serious illness strikes.16 In the more severe cases, only by “spending down” assets can the victim acquire medically indigent status and thus qualify for Medicaid.

It is unrealistic to assume that current public and private pension programs can expand sufficiently in real terms to provide adequate health and social services coverage for all elderly. The major intent of the 1983 Social Security Reform Act (PL 98-21) was to keep the current system solvent while appearing not to retreat substantially from the nation’s ongoing commitment to retirees; there was virtually no public discussion of benefits expansion.17 Moreover, there has been continuing, and per-
haps understandable, resistance from employers to index pension benefits against inflation.\textsuperscript{18}

One interesting new financing concept which, if broadly embraced, might allow a significant number of elderly to pay for a substantial portion of their medical care is home equity conversion. In such schemes (for example, reverse annuity mortgages and sale leaseback plans), the homeowner sells to an investor who agrees to provide the seller with a veritable multiyear income stream of payments and permit the seller to continue living in the home for some specified extended period, typically until death. Yet, the extent to which this financial potential for LTC support will be realized nationally remains uncertain.\textsuperscript{19}

**New taxes earmarked for long-term care?** This oft-discussed possibility was indeed a major recommendation of the President’s Advisory Council on Social Security when it took up the problem of Medicare financing in late 1983.\textsuperscript{20} Despite interest group opposition, it is true that within the past three years, the federal excise taxes on both cigarettes and liquor have been increased significantly (the former doubled, from eight to sixteen cents a pack, and the latter hiked up $2.00 per 100-proof gallon). If Congress retains, or further increases, these levies, and if the resulting billions in new revenues were earmarked for Medicare and Medicaid, an important additional source of funds would be created to help close the trust fund deficit and perhaps even support some service expansion. Further, from an equity standpoint there is a chain of evidence suggesting these taxes would fall disproportionately on “high cost” users of medical care.\textsuperscript{21} In fact, the political prospects for keeping (or tightening) these taxes do appear, if anything, favorable at the moment. But the likelihood that Congress or the administration would target these funds for anything but deficit reduction seems remote, given the tenor of fiscal policy debate in recent months.

**Private insurance for long-term care?** One much-discussed but still relatively underexplored alternative for protecting the elderly is private health insurance coverage for nursing home and other major long-term care expenses. Currently, virtually all such insurance is of the “Medigap” variety and pays, in total, only about 1.5 percent of the nation’s nursing home bill for the elderly. The critical question is whether comprehensive LTC insurance can be made actuarially sound and affordable to that broad mass of the elderly living above the poverty line but off the “Main Line.” The historic perception that LTC is uninsurable is largely untested and could well prove to be in error.\textsuperscript{22} But there can be little doubt that an accelerated growth—indeed, the real prospect of such growth—in the liquid assets of the elderly would create at first the perception, and then later probably the reality, of a stronger effective demand for LTC insurance. Arguably, this is precisely what is needed to induce insurers to bear the start-up costs and financial risks of aggressively marketing LTC insur-
Stimulating increased private savings for LTC. If citizens of all ages could be induced somehow to save more out of current income, many (though certainly not all) could accumulate “nest eggs” large enough to support much of their LTC in retirement. That this will happen without new policy initiatives seems unlikely, however. Over the 1973-83 decade, the U.S. private savings rate declined nearly 30 percent, so that in 1983 personal savings amounted to only 5 percent of personal disposable income. Despite 1981 eligibility liberalizations, only 17.5 percent of salaried workers had individual retirement accounts (IRAs) in 1983.

Can the IRA concept be refined in a way that induces more citizens to participate, leads participants to save more, and then effectively channels these savings into LTC, as needed, in retirement? This question has inspired at least four recent LTC financing proposals (each apparently developed independently of the others). They differ considerably in concept and detail, but share in common the IRA-for-LTC feature.

William D. Fullerton has proposed that taxpayers be given new incentives to establish “long-term care” accounts with financial institutions. Beginning at age forty, individuals could deposit up to 2 percent of taxable income, up to $1,000 per year, into such an account. The first $250 would be treated as a tax credit and the remainder, as a tax deduction. Interest earnings on the account would not be taxed. Funds in the account could not be withdrawn until the owner reaches age sixty-five, at which time a broad array of medical and social services (including insurance) could be purchased from it. For the poor and near-poor, Fullerton would guarantee a federally defined set of long-term care services to all Medicaid eligibles aged seventy-five and over and to all persons qualifying for Supplemental Security Income on the basis of disability. To pay for these he would establish a national lottery, part of whose proceeds would also flow to the states to support new and innovative LTC services.

A plan that would use “Health Bank IRAs” to achieve fundamental reform of Medicare financing has been proposed by Ferrara, Goodman, Musgrave, and Rahn. Workers and their employers would be permitted dollar-for-dollar tax credits, up to some fraction (e.g., 2 percent) of Social Security taxable income annually, for contributions to these IRAs. Funds would accumulate tax free and could be used in retirement for LTC insurance and other health expenses. Workers not choosing to establish such accounts would, upon retirement, receive vouchers pegged actuarially to the net value of the payroll taxes paid cumulatively by such workers and their employers. For all retirees, the federal government would provide catastrophic insurance to cover medical expenses exceeding a high deductible; the latter would be actuarially determined so as to reflect the anticipated size of the individual’s Health Bank IRA or voucher,
as the case may be. For the poor and near-poor there would be means-tested coverage of expenses below the catastrophic insurance deductible limit. Over time, the current Medicare system would be phased out.

H. R. 1791, introduced in March by congressman William Dannemeyer (R-CA), would give each employee the option of selecting a higher deductible health insurance plan in return for an employer contribution to an IRA. This tax-exempt contribution could be equivalent in amount to the difference in the premium costs of the higher deductible plan and a designated low deductible plan that the worker otherwise could have chosen. Any financial institution handling such an IRA would have to agree to extend the employee a line of credit for family medical emergencies at least as large as the deductible in the employee’s selected health plan. Such loans could be repaid out-of-pocket or by drawing down IRA funds; the portion of the latter consisting of employer contributions would be subject to taxation at that time, however.

A fourth proposal incorporating an IRA-like feature is the NHCT plan.

National Health Care Trust Plan

**Tax and transfer policy changes.** Current regulations, which unconditionally exempt employer (but not employee) contributions toward the purchase of health insurance from employee taxable income, would be replaced with a more strategic set of provisions. For persons employed in either the private or public sector, or self-employed persons, tax and transfer policies would be instituted to legally define and encourage the growth of what we term “Health Care Trust Accounts” (HCTA). A HCTA is an interest-earning trust fund account established in the family’s name as a vehicle for expanding opportunities for planning and making medical expenditures over the life cycle. Each family would be legally entitled to one HCTA into which payments could be made from several sources.

First, the federal government would, for families that qualify, make a tax-free transfer of funds into the account each year. The actual amount would vary with family size, income, and perhaps other demographic characteristics that might predict medical expenditures (for example, race, geographic region). Based on these characteristics, families would be assigned to actuarial risk categories, in much the same way Enthoven’s market reform plan envisions.

Families with incomes at or below some government-determined floor would receive the maximum basic HCTA grant; as family income increased beyond this floor, the basic grant would decrease linearly and disappear entirely when income reached some government-determined ceiling level. In all computations related to the basic grant, “income” is defined to exclude those private sector (employer) contributions to HTCA that qualify for tax exemption and also HCTA interest earnings.
Determining the amount of the maximum grant represents a nontrivial exercise in balancing depth of program coverage for families against the resulting tax expenditure leakages that put pressure on the federal deficit. For now we propose that the maximum basic grant for a qualifying family be equal to the projected annual medical expenditures for a family in its risk category. This has the virtue of ensuring (as a rough first approximation) that a poverty family could purchase an actuarially fair health insurance policy entirely out of HCTA funds. The floor, ceiling, and the size of the basic grant would be specific to each actuarial category.

To illustrate the mechanics of the basic grant, consider the following example. Suppose a family of four (husband, wife, two children) has an annual income of $4,500, that the federal income floor for this family is $5,000/year, and that expected annual medical expenditures for this actuarial risk category are $1,000. Then this family would receive a basic HTCA grant of $1,000 per year, so long as annual income remained at or below $5,000. Suppose another family of four has an annual income of $30,000, that the federal income ceiling for this family size is $25,000/year, and that expected family medical expenditures are $1,500. Then, this family receives no HCTA grant, and would not until income dropped below $25,000. Finally, suppose another family of four has an income of $15,000, actuarially projected medical expenses of $1,200/year, and faces a $5,000 floor and $25,000 ceiling on annual income. Then it would receive a grant of $600, computed from the following general formula (valid in general for an actual income lying between the ceiling and the floor):

\[
\text{Basic HCTA grant} = \left(1 - \frac{\text{actual income} - \text{income floor}}{\text{income ceiling} - \text{income floor}}\right) \times \frac{\text{expected annual medical expenditures}}{\text{expected annual medical expenditures}}
\]

The second form of payment to the family's HCTA would be employer and employee contributions. Up to some government set annual limit, these would not be included in the employee's taxable income and would be excluded from the salary base upon which Social Security taxes are computed. The annual private contribution cap (for instance, $1,500/year) is defined on a per family, not per worker basis (for families with multiple workers) and would vary with family size. (Thus, employer contributions to two working spouses might have to be coordinated to keep the family within its annual ceiling.) The cap would not be affected by the amount of any HCTA grant received from the federal government. In essence, grants and employer-employee contributions to HCTA are additive.

Thus, like Enthoven's proposal, the NHCT plan would sever, in a formal sense, the traditional link between jobs and health insurance; the individual worker could direct part of his or her salary into the HCTA.
without extensive negotiations. Yet, in practice, labor will still likely come
to the bargaining table with a unified position on its members’ demands
for HCTA contributions. Similarly, labor will still press management to
consider these contributions as rightfully part of the fringe package—a
bargaining stance consistent with maximizing total worker compensa-
tion. Management should react to such demands no differently than at
present, since its HCTA contributions would be afforded the same tax
treatment as health insurance and pension contributions today (except
for the HCTA tax cap provision).

Third, self-employed persons may likewise make tax deductible con-
tributions to a HCTA up to the pre-set annual limit.

Fourth, HCTA interest and dividend earnings accruing in the
preretirement years would be exempt from income taxation if the family
chooses a health plan providing adequate coverage against catastrophic
medical costs. Otherwise, HCTA earnings would be taxable as income in
the usual way. Funds withdrawn in retirement could be taxed either at
the generally modest rate then applicable to the family—as is the case
with IRAs and private pensions—or else at lower and more progressive
rates. The intent here is twofold. First, for reasons discussed below, one
wants to strongly encourage the purchase of catastrophic insurance.
Secondly, one wants the HCTA, as an investment instrument, to be at
least as attractive as the general IRA, which today lures fewer than one in
five workers. In this regard, HCTA funds may be used in retirement only
for medical and health-related social services, whereas the IRA is unre-
stricted. Consequently, one can argue for differentially favorable tax
treatment for HCTA so that investment in this account appears as attrac-
tive to the rational family as an IRA investment.

Fifth, the health care trust account would be “owned by the family” in
much the same way that a home may have joint ownership. Each
HCTA’s legal title would bear the names of one or more adult members
of the household, who are thereby entitled to make all decisions about
fund disbursements in both the pre- and postretirement years. Family
members (including minors) not listed as joint owners may nonetheless
use HCTA funds at any time at the discretion of the owners, for a wide
range of medical services. Changes in family composition need pose no
greater obstacle for HCTA ownership than for home ownership. In the
case of divorce, HCTA assets could be divided between both parties by
private agreement or by the courts. Either way the result would be the
legal dissolution of the original HCTA and the spawning of two new
ones. In case of the death of one or more (but not all) joint owners, sole
title to the HCTA would stay with the surviving owner(s). The last
surviving owner can bequeath the unspent balance of the HCTA to
anyone without restrictions and exempt from inheritance taxes. These
provisions ensure that the account stays within the family that contrib-
uated to it, while dampening incentives to deplete the HCTA solely in anticipation of the death of the last surviving owner.

**HTCA in the preretirement years.** The family may withdraw funds from its HCTA at any time without penalty to cover the costs of a broad, government-designated set of basic medical categories: hospital, physician, dental, optometric, psychiatric, and possibly others. To accomplish this, account funds could be used in any one of three ways: (1) To purchase conventional cost-reimbursement medical insurance, which would typically feature some deductible and copayment rate. To qualify for participation in the NHCT plan, the insurer would have to offer a well-advertised “open enrollment” period at least once each year during which any family participating in the NHCT plan could choose among the policies offered by the insurer. HCTA funds could be used to pay for both the premium and out-of-pocket expenses that arise because of cost sharing, and for health services not covered under the policy. (2) To join an HMO or similar prepaid capitation plan, which would also have to offer an open enrollment provision to qualify for receipt of HCTA funds. (3) To purchase medical care directly, through what amounts to a self-insurance arrangement. The family would charge medical expenses against its HCTA with a credit card that would have to be accepted by any provider wishing to participate in the NHCT plan.

But are catastrophic costs adequately covered under these arrangements? HMO-like plans do shield members against most out-of-pocket expenses once the annual premium is paid, but such is not the case under options (1) and (3) above. Basically, we contend that the health care trust account should not serve as the principal vehicle for financing major medical outlays. Many such expenditures (for example, those arising from accidents or major organ failure) are highly price inelastic and not likely to be deterred by copayment. Instead, the family would likely draw upon HCTA funds as needed—in effect, biting a large part of a large bullet and thereby depleting the account. This would thwart HCTA’s role as a support fund for long-term care.

To counter this we propose an additional incentive: the family would qualify for the tax exemption on HCTA interest and dividend earnings only if it enrolled in an insurance plan that placed a ceiling on annual out-of-pocket medical expenses. The latter include all HCTA outlays plus any other medical charges borne by the family as a result of its account being depleted. The ceiling might be expressed in absolute terms (such as $2,500/family/year) or percentage terms (10 percent of family income). Once total out-of-pocket outlays exceeded the ceiling, the catastrophic insurance plan would have to provide complete coverage.

**Promoting fair competition.** The National Health Care Trust Plan would intensify the pressures already emerging for greater competition in the medical marketplace. The individual family would have unprece-
dented motive and opportunity to evaluate the quality/cost tradeoffs embedded in major medical decisions. But would not the typical family find the choices too many, the details too arcane and overwhelming, the uncertainties too pervasive in everything from the efficacy of surgery X to the rate-of-return on investment Y? The individual family might indeed, but its chosen trust administrator (discussed below) would possess the financial incentive and organizational capability to gather and analyze for the family the available health insurance options, investment opportunities, and other data pertinent to planning over the life-cycle.

Would the NHCT plan, as described thus far, result in fair competition among, alternative types of health plans? Obviously, we predict that it would. Despite evidence they can generate substantial cost savings under some circumstances, we have tried not to bias the proposal in favor of capitation-based health plans. First, it is still unclear to some observers whether these apparent cost savings represent real efficiencies relative to cost-reimbursement/fee-for-service plans, or result rather from provider and patient self-selection biases or other factors limiting valid generalization. Secondly, the proper role of a procompetitive strategy is to remove the barriers from, and perhaps positively encourage, the evolution of a wide spectrum of health care alternatives. Each family then chooses on the basis of perceived costs and benefits.

Indeed, by providing families with a clear self-insure option, the NHCT plan would challenge both cost-reimbursement and prepaid capitation plans to generate insurance alternatives that can survive a stiff market test. As Laurence Seidman wrote recently: “Some HMO advocates contend that in fair competition HMOs will gradually overwhelm fee-for-service, but such an outcome is doubtful. Whatever the result, however, what matters for consumer welfare and economic efficiency is that the competition be fair and not improperly biased toward HMO or fee-for-service. . . . May the arrangement preferred by most consumers win.”

HCTA in the retirement years. Upon reaching age sixty-five, a family member could use HCTA funds dollar-for-dollar to pay for a wide array of medical and social services under the heading of long-term care. Eligibility would be based solely on age, not job status. So long as at least one of the account’s joint owners continues to work, the family could make tax-deductible contributions and the government would make basic grant payments to the HCTA according to the usual criteria. The able elderly should not be discouraged from staying in the labor force. Under the NHCT plan, they need not retire to begin having greater financial access to LTC services, including those, like physical therapy, that would help keep them functionally active longer.

Once all of the account’s joint owners retire (and assuming the family does not qualify as medically indigent), the government would declare the family’s HCTA to be “fully matured” and would discontinue all grant
and tax benefits. However, if the family were medically indigent, the government would continue these benefits without interruption into retirement. In the early going, we envision the health care trust account as basically a supplement to Social Security and Medicare, plugging current gaps in federal and state coverage of LTC and possibly generating an effective demand for new services. HCTA funds could help pay for extended care services, nursing home care, home health services, physical and occupational therapy, drugs and appliances, mental health care, eyeglasses, dental care, physician and hospital services, and hospice care.

New strategies to extend and enhance long-term care could be bolstered by HCTA funds. The emergence of a critical mass of HCTA accounts—with their implied aggregate purchasing power—would likely spur the introduction of a diverse selection of private LTC insurance policy options. This in itself would be a positive development for HCTA owners, since the greater their risk-spreading capability, the less their need to amass enormous accounts to hedge against such catastrophic expenses as continuous nursing home care.

Some years hence, if such a National Health Care Trust Plan were solidly established and successfully generating HCTAs, there would doubtless be political pressure to reduce the size and scope of both Medicare and aspects of Medicaid. And for financially plausible reasons, there would likely be less popular resistance then to such moves than what we are now witnessing. Thus, the NHCT plan is a “Medicare reform proposal” as well.

The trust administrator. Under the current institutional arrangements, a (nonpoverty) family typically has two distinct types of agency relationships to assist with the seemingly distinct problems of purchasing medical services and investing for retirement: the doctor-patient relationship for medical care and relationships with banks, savings and loan associations, insurance companies, brokers, attorneys, and other counselors for investments. The health care trust account would establish a stronger interdependence between medical care decisions and general financial investment decisions. We predict the relevant actors here (families, employers, medical providers, investment firms) will recognize this new interdependence and seek to exploit it—a result which, under appropriate ground rules, will generate a set of private sector checks and balances that promotes medical market competition and encourages HCTA growth.

Under HCTA there will be incentives for the emergence of a new organizational entity, the “trust administrator” (TA): a legally established private sector organization selected by the HCTA owner to manage both the investment and medical purchasing activities connected with the account. In a properly functioning system, each HCTA owner would choose among several trust administrators competing for the right to manage this account. The TA is ultimately responsible to account own-
ers, who could—at specified open enrollment periods held at least annually—switch administrators in search of more effective management. During these periods, the TA would be expected to accept all HCTA applicants, including accounts owned by the medically indigent. (The adverse risk selection problems this could generate are discussed in the next section.)

While an entirely new type of private sector entity might emerge, it is likely the role of the trust administrator can be adequately filled by a variety of existing organizations. Among these are: insurance companies (health and life), private pension trustees within individual firms or labor unions, banks and savings and loan associations, brokers or other investment counselors, and independent contract benefit administrators.

In its “supra-agency” relationship with HCTA owners, the trust administrator would function: (1) As central banker for all “checking account” transactions involving HCTA funds. The TA would process current medical charges against the account and pay providers. It would ensure that all work-based contributions, any other private deposits, and basic grants from the government were properly received. The TA would be permitted to assess HCTA owners a surcharge for such services; the amount would be regulated by the tightness of competition among TAs for HCTA funds. (2) As central banker for all “savings account” transactions involving HCTA funds. Each TA would invest funds in a portfolio with expected yield and risk characteristics thought to be attractive to HCTA owners. The TA and the owners’ would share profits in ways that would probably vary with the portfolio. In all cases, the TA would have to maintain sufficient liquidity to cover the day-to-day disbursement of funds to providers. (3) As financial counselor and ombudsman for the family. The TA would help HCTA owners forecast their LTC financial requirements and aid in estate planning.

The TA would also do comparative shopping in the medical marketplace since there is a strong incentive to ensure that HCTA owners get value for their money. The opportunity cost of any medical purchase from HCTA is the after-tax investment return on these dollars, and this is a cost borne by the TA as well as the account owner. Consequently, most TAs would find it economically rational to acquire extensive information from providers on fees and other practice characteristics, including hospitalization rates and the resource intensity of medical treatment for certain high-use diagnostic categories. The TA would also play a special ombudsman role in the financially critical decisions concerning the triage of “clients” from hospital to nursing home care, and from the latter to home care. We envision the TA working jointly in this regard with hospital discharge officials and LTC providers.

The trust administrator could not, as we now envision it, establish utilization ground rules that unconditionally restrict the family’s freedom
of choice among licensed providers. However, a HCTA owner and the TA might enter into a voluntary agreement in which the former would choose preferred providers from among those recommended by the trust administrator in return for the guarantee of a greater rate-of-return on HCTA investment that would be available if full freedom of choice were exercised.

Each TA would have to recognize the government-designated set of basic medical categories and would have the option of paying for categories beyond the basic set, for example, unlimited mental health care or podiatry services. The TA would be required to give HCTA owners substantial advance notice (perhaps one year) before rescinding coverage of any optional category.

Properly monitored, the trust administrator can evolve into the principal regulatory agency for the medical market of the future. Unlike its predecessors (for instance, Health System Agencies), the TA’s power would derive from its financial acumen and its marshaling of market information for those who have strong incentives to use it.

Enfranchising the poor and near-poor. Admittedly, it is highly unlikely a Medicaid-eligible family could ever amass a HCTA as large as most nonpoverty families, who are able to steadily infuse the account with employer contributions while drawing funds down at a slower rate because of better health status. This outcome could largely be averted by sufficiently large annual injections of basic grant funds into the HCTAs of poor and near-poor families. But this would significantly inflate the near-term cost of the entire NHCT plan and possibly generate serious fiscal and political problems.

Instead, we propose that government keep alive all HCTA inducements for persons age sixty-five or above who qualify as medically indigent, regardless of employment status. Compared with the general case, this would guarantee each indigent person an uninterrupted flow of basic grants and catastrophic insurance vouchers as long as he or she lived.

Would the TA really act conscientiously on behalf of the poor? And would the poor have the information and financial acumen necessary to assess the quality of this stewardship? Only experience can resolve these issues. If the verdict were unfavorable, additional safeguards and options for the poor would be appropriate, such as tougher enforcement of banking, insurance, and Employee Retirement and Income Security Act (ERISA) regulations; closer TA monitoring by government; and public disclosure of questionable TA practices. As many a physician will testify, even the accusation of malpractice is something to be avoided.

With these provisions in place, Medicaid would essentially have been reworked, federalized, and incorporated into the larger National Health Care Trust Plan. If complete federalization were not desired, the costs of
all grants and vouchers could be shared by the states and the federal
government on a formula basis.

Some Difficult Issues

While medical market reform based around the NHCT plan would
necessitate a number of administrative, fiscal, and, ultimately, political
decisions, we think at least four major issues would generate prominent
scrutiny early on. Indeed, virtually any comprehensive reform plan in this
area will, or should, raise similar questions.

Would families actively participate? What about the case of the non-
poverty family who, deciding that Medicare and Medicaid are here to
stay, does not elect to take part in the NHCT plan? We believe this
would not happen often because a family opting out of the system alto-
tgether would have no health care trust account and would have to pur-
chase medical care and health insurance in after-tax, nonsubsidized
dollars. This is a strong incentive indeed to get on board.

Would the health care trust account function as intended? In partic-
ular, would the family refrain from current spending out of HCTA suffi-
ciently to amass a significant retirement fund? While the marginal
propensity of Americans not to save has been noted, there are at least
three reasons to be more optimistic about this under the NHCT plan.

First, the erstwhile cafeteria-style employee benefit plan that features a
flexible spending account (FSA) can be viewed as a rough prototype of
the health care trust account. These two “benefit bank” schemes share in
common the important feature that monies allocated to the account in a
given year (whether by salary reduction or employer contribution), but
not spent in that year, may be retained by the employee for future use.
There are, however, significant differences. Total annual tax-
deductible contributions to HCTA would be capped, whereas they were essentially
open-ended in the FSA above. Secondly, employees with FSA cafeteria
plans could, depending on the employer, allocate pre-tax dollars across a
variety of options: health insurance, retirement savings (via “401(k) ac-
counts”), legal services, day care, vacation days, and to the account proper.
Cash (or benefit credits) placed in the latter could pay for such employee
expenses as uninsured medical costs. On the other hand, there would be
only two permissible uses of HCTA funds—basically, health care now
and health care in retirement. Despite these differences, we think it is
instructive to examine trends in employee benefit selection in FSA cafe-
teria plans during the brief interval, approximately 1981-83, in which a
number of large corporations began offering them.38

A 1984 survey analysis by the Employee Benefit Research Institute
(EBRI) concluded that, “Health insurance plans in the broad-based flex-
ible benefit plans surveyed have significantly higher levels of cost sharing
than do [health] plans in the nation as a whole.” Specifically, employees in firms with broad-based flexible plans selected insurance with an average deductible of $207, in contrast with the nationwide average across all medium and large firms of $100. Of the twenty firms so characterized in the EBRI survey, sixteen—that is, 80 percent—incorporated health-expense FSAs in the cafeteria plan arrangement. A separate 1983 survey by a large management consulting firm of twenty-three major companies offering flexible benefit packages (most featuring FSAs) found that, on average, 43 percent of employees chose medical coverage other than the “richest” offered by the firm.

Some observers have outright asserted that FSAs will not control medical costs (nor, by extension, federal tax expenditures) because any employee who thus selects a high-deductible insurance plan will simply use the FSA to pay the deductible, as needed, and other uninsured medical expenses. Thus, the putative cost sharing is fictitious. But as the EBRI analysis suggests, this claim ignores some key points. First, although such an employee may use the FSA to purchase (in pre-tax dollars) more uninsured health services than otherwise, the tendency here to choose policies with greater cost sharing means an incentive to economize on big ticket items like hospital admissions; the net effect on employee health outlays is unclear and could easily be favorable in many cases. Further, using FSA dollars to cover uninsured medical expenses, including a deductible, has a genuine opportunity cost to the employee in terms of foregone benefits elsewhere in the cafeteria plan. In such cases there is still more incentive to be medically cost conscious than under the traditional, employer-paid, “first-dollar coverage” insurance plan.

Beyond the theoretical debate about conflicting incentives is the emerging evidence that firms instituting FSA cafeteria plans actually did lower, substantially, the rate of increase in employee medical expenses. A prominent example is the Quaker Oats Company’s Health Incentive Plan, which company officials claim was responsible for holding the rate of increase in health costs per employee to 5.6 percent in 1983—rather than the 20-25 percent projected under its traditional benefits framework. The Quaker Oats experience is all the more striking when one realizes that the amount the firm spent on health claims, per se, decreased 8.5 percent over the same period. About 75 percent of the savings came from lower employee utilization of services, company officials have reported. Over the previous ten-year period, health costs at Quaker Oats had increased 283 percent. Introduction of an FSA at Berol Corporation reduced total medical expenses 20 percent below what had been projected for the plan’s first year of operation. After PepsiCo. introduced its cafeteria plan, the annual rate of increase in medical costs was almost halved (from 17 percent to 9 percent); similar results have been reported at the American Can Company. Among the earliest FSA
innovators was a group of Mendocino County, California, school systems, which offers employees insurance with a high ($500) deductible and then deposits $500/year into each employee’s “stay well account.” What the employee does not spend from the account on medical expenses is received in cash when he or she leaves the school system. Over the 1979-83 period, 23 percent of employees withdrew none of their “stay well money,” and the school systems realized a cumulative savings in insurance premiums of $25 million.

The weight of evidence to date suggests, that an FSA cafeteria plan can induce employees to economize on health care spending, with the resulting cost savings channeled to other parts of the benefit package.

But suppose the only two items on the cafeteria menu are health care and tax-deferred retirement income, as in the health care trust account? Unfortunately, our “natural experiment” involving FSAs falls short of providing examples of such accounts. Still, there are reasons to anticipate that the HCTA will function, for most families, in ways that tend to balance current health care and long-term care needs. The first factor, potentially, is the typical family’s awareness that even with Medicare and Social Security, it may not be able to afford adequate LTC in retirement. Unfortunately, there is evidence that many families today simply do not appreciate this. A recent survey of retirees indicated that 80 percent of those anticipating LTC needs thought they had substantial coverage for these services under Medicare, while nearly 50 percent believed their private “Medigap” policies would be adequate.

Under the NHCT plan, the TA has the motive and opportunity to disabuse any client-family of the notion that frugality can be forgotten merely because Medicare will survive in some form. The critical point here is that countervailing the family’s probable propensity to allocate HCTA funds to current uses are the TA’s incentives—both as a responsible steward for the family and as a business enterprise—to encourage the family to use the account also as a tax-advantaged savings plan. For only then will the family build a nest egg and the TA earn a profit.

**Adverse risk selection?** Virtually any procompetitive reform proposal that encourages families to tailor their health coverage to their perceived risk of illness can generate adverse risk selection in insurance markets. Persons expecting to be healthy will tend to purchase less costly, less comprehensive policies—or, in some cases, not insure at all. Those anticipating significant medical expenditures will tend to opt for broad coverage with minimal cost sharing. Compared with the more traditional case where both types of risk are pooled in a single-premium, community-rated plan, the situation described above can lead, in theory, to the insurance market becoming segmented, with experience-rated, premium-differentiated policies offered to each risk category. This can cause serious equity problems and, in the limit, market failure. Higher risk families,
who also tend to be poorer, may then face a much higher premium than in a community-rated setting where the low users of care, in effect, subsidize the high users. If, in such a segmented market, the overall cost of health insurance to the high risk families begins exceeding their ability to pay, the demand for insurance sags, the risk pool further deteriorates, and even fewer affordable policies are offered to this group.

This is, of course, a stylized depiction. It would be unfair, at this point, to damn every procompetition proposal on this basis. For instance, Enthoven’s original plan proposes specific measures to protect those who are poor health risks. Still, it is no coincidence, we believe, that the problems of the uninsured medically indigent have appeared to worsen just as competition in health markets has intensified; the cruel economic logic of risk selection is arguably already at work.

There is the potential for this problem in the NHCT plan, as well. The trust administrator has obvious incentives to attract HCTAs from physically and economically strong families. Moreover, many among the chronically sick and poor would own small accounts, consisting mainly of federal basic grants; the investment return on the residual of such accounts might not even cover their imputed share of TA operating cost. Without further inducement or regulation, the profit-motivated TA might try to avoid (perhaps simply refuse) such accounts, leaving disadvantaged families the choice of either going without TA services altogether, or selecting an administrator with such a “high loading” that financial benefits are dissipated. To the extent adverse risk selection further widens the difference in the cost of insuring low income and higher income families, the TA’s incentives for favorable risk selection are intensified.

Yet, there are features in the NHCT plan which would tend to blunt these effects. There are also additional counter-measures government can take—though at some cost—to defuse risk selectivity problems.

The NHCT plan, as proposed, requires each participating TA to advertise a government-supervised “open enrollment,” at least annually. The TA can attempt to be evasive, for example, inconvenient registration locations, but it cannot refuse an application. Recall also that medically indigent families would be awarded income-scaled vouchers to purchase catastrophic health insurance. From the TA’s standpoint, such policies would function as a “stop-less” mechanism to staunch the outflow of HCTA funds in the event of major medical expenditures.

Beyond this, there are at least two other steps government can take. One option is to establish some “critical value” for the ratio of medically indigent families to total families in a TA’s client pool. The TA would not be obligated to accept new applications from medically indigent families once the “critical value” proportion of these families had been signed up. This risk-spreading provision is designed to weaken the TA’s incentive to thwart the intent of the open enrollment provision. Admit-
tedly, setting the critical value ratio in a way that balances indigent family demands and TA supply is a nontrivial administration problem.

The other option is to provide medically indigent families with basic grants large enough that they no longer appear financially unattractive to trust administrators. The problem, of course, is that this could be an expensive undertaking for government. To the degree it is pursued, this option represents an overt, consensus-generated public subsidization of health coverage for the poor under the NHCT plan. It is a subsidy designed to replace, in some measure, that tacit and financially uneven cross-subsidization of care for the poor that has occurred traditionally in employer-based health insurance plans.

**How much would it cost?** First, the impact of the NHCT plan on net federal outlays is truly a complex matter. For example, the budgetary costs of basic grants and catastrophic insurance vouchers would be offset, in some significant degree, by corresponding contractions in Medicaid and Medicare’s spending on the indigent. Similarly, it is an open question whether the NHCT plan’s proposed cap on annual tax-deductible contributions to the dual-purpose health care trust account would lead to larger, or smaller, tax expenditures than are generated for health insurance alone under the current rules, which do not cap employer contributions but do exclude the self-employed. An extremely important long-term consideration is that to the extent HCTAs do lead to increases in the personal savings rate and then to private sector investment, economic growth would be stimulated and the tax base itself broadened. But projecting this effect accurately requires, among other things, that we make due allowance for the projected fraction of HCTA investment funds that would otherwise have gone into private pensions and “regular” IRAs anyway. To assess these expenditure effects, the tax and transfer parameters of a prototype NHCT plan must be specified and then embedded, in a modeling sense, in the health and income security milieu within which such a plan would actually operate.

Secondly, we can aver that the direct transfer payment and tax expenditure costs of the NHCT plan are largely controllable by the federal government. The size of the maximum basic grant, the manner in which it declines as family income increases, the cap on private sector contributions to HCTAs through the workplace, various inflation adjustments—these and other program parameters, which largely determine annual federal payout, are fully set by the government. The program can be as generous, or as parsimonious, as government wishes.

**Achieving Lasting Reform**

In devising an implementation strategy which decisively, though not irrevocably, sets the wheels of the NHCT plan in motion, but respects
the incremental nature of most federal policy making, we propose two phases.

Phase I. We suggest first amending the Internal Revenue Service code to remove health insurance from the current list of nontaxable fringe benefit items, but at the same time formally establishing the concept of a restricted flexible spending account, to be called the health care trust account. The HCTA would have the following specific features: (1) It may be used only for health insurance of all types, noninsured health expenses, and tax-advantaged “capital accumulation” benefits—such as the 401(k) account—that induce prudent saving and investment for retirement income. In retirement, the income generated over the years via the HCTA could be used only for long-term care services. (2) Any employee or self-employed person may establish what amounts to “family coverage” under such a spending account, so long as no other family member has an active account. Employers, employees, and the self-employed may make unlimited contributions to a HCTA, but there would be an annual ceiling on the total amount of tax-exempt contributions. (3) The worker would not be required to make an irrevocable (indeed, any) decision, before the accounting year begins, about the allocation of new HCTA contributions between current health services and capital accumulation for future health services. The choice between these two permissible uses of HCTA would be fully flexible at all times. (4) Since all HCTA balances not spent on current health care must, by definition, be allocated to capital accumulation and since the latter, by definition, is an ongoing process, the troublesome question of year-to-year rollovers of unspent account balances is moot. There would be no unspent HCTA balance at year’s end; that is, you don’t have to lose it since you have indeed used it—for capital accumulation. (5) To manage the spending and investment activities within the HCTA, each employee would be free to choose any organization qualifying as a trust administrator, as discussed shortly. In particular, employer- and union-affiliated organizations could qualify, as well as a range of traditional financial institutions. (6) The nondiscrimination rule in the IRS code that requires a firm to contribute to the health plan of each employee not less than 75 percent of the cost of its most expensive health plan [Section 125 (g) (2)] should be modified to refer only to firm contributions to health care trust accounts. This would, at once, broaden the scope of protection against discrimination in fringe benefit contributions, while providing each HCTA owner with maximum flexibility about the size and price of the health plan to be purchased with account funds. (7) All other rules pertaining to flexible benefit plans would remain as established under the Revenue Act of 1978, the Deficit Reduction Act (DEFRA) of 1984, and accompanying IRS interpretations.

The second major requirement under Phase I would be to amend the
ERISA and state banking and insurance rules, to define and set performance standards for the trust administrator. Any profit or nonprofit organization thus wishing to manage HCTA funds would be subject to an enforceable set of federal and state regulations, as proposed earlier.

This strategy involves comparatively little up-front cost and complication, at least for the federal government; essentially, the tax laws are changed in a prescribed way and the private sector responds in some measure. If the response is great, there will be a tax expenditure leakage, but this is capped on a per family basis and need not exceed the current tax drain arising from the unlimited deductibility of health insurance premiums. More importantly, if many families are responding the way theory suggests, this would help pave the way politically for Phase II.

**Phase II.** In Phase II the basic grant system would be set up, in the U.S. Department of Health and Human Services and administered in each state by its department of health or human resources, much like Medicaid today. Medicaid would be phased out with the incorporation of basic grants into the NHCT plan.

What are the political chances of enacting such a reform strategy? Realistically, legislating just Phase I of the NHCT plan would represent a formidable challenge at the moment. First, some would argue the “tax cap” (on deductible contributions to health insurance purchases) is an idea whose time, politically, has come and gone, if it ever did arrive. Indeed, after twice proposing such a cap, the Reagan administration, in its latest tax plan (“Treasury II”), reversed itself and recommended including in taxable income the first $300 an employer contributes to family health coverage. Moreover, if there is a prevailing mood in Washington about fringe benefits, it is to attack them as inconsistent with an equitable, efficient tax system—not liberalize them with such gadgetry as flexible spending accounts.

But a closer examination of the current environment suggests other reasons for optimism. First, our proposed limit on tax-deductible contributions to HCTA may meet with less hostility than the tax cap on health insurance, per se. Under the NHCT plan, such bullet-biting might be more palatable to medical providers, insurers, labor unions, and firms because it is accompanied by new benefit provisions to stimulate the demand for certain types of services, mainly LTC, in the long-run while reorienting, rather than so visibly reducing, the typical worker’s fringe benefit package. In proposing to create a system of health care trust accounts managed by trust administrators, the NHCT plan could effectively provide the compensatory measures to make the cost control aspects of the strategy more acceptable.

Early evidence that a tax cap on contributions to a package of fringe benefits may be politically tenable emerged in the tax debate of 1984. With the support (among others) of major corporations anxious to retain
the flexible spending account concept, former Rep. Barber B. Conable, Jr. (R-NY) and Sen. Bob Packwood (R-OR) developed a proposal to recognize FSAs as part of a cafeteria plan; but the dollar size of the FSA, and thus of tax-advantaged contributions to it, would have been capped. While the proposal was not finally incorporated into DEFRA, what is significant is the apparent support it got—cap and all—from parts of the business community.

A second encouraging factor is that the individual retirement account, of which the HCTA is really a special case, is thriving politically in Washington because of concerns about savings, investment, and long-term economic growth. Despite the federal deficit crisis, the administration has most recently proposed to increase significantly the total annual amount a family may contribute tax-free to IRAs. The problem, as noted earlier, is that fewer than one in five employees now take advantage of IRAs, despite liberal tax inducements already in place.

We believe the NHCT plan—under which each family’s HCTA is its (LTC) IRA—would naturally lead families to confront the consumption/saving decision head on. A family wouldn’t have to save, but it would at least have to think about it—the trust administrator would make sure of that. This important tradeoff feature is also captured, to a significant degree, in Rep. William Dannemeyer’s proposal (H.R. 1791) discussed earlier. Thus, rather than regarding the NHCT plan (or the Dannemeyer proposal) as some complicated fringe benefit bonanza running cross-current to the spirit of lean, clean tax reform, it should be evaluated dispassionately in terms of its strategic policy aims: stimulating fair competition and savings for LTC.

The politics of Phase II of the NHCT plan would be less complicated, yet more difficult. Anything resembling a negative income tax—as the basic grant program does in a restricted sense—has been a Congressional bête noir. Historically, politicians have preferred giving ‘the poor entitlements to medical services rather than cash to shop for them, no doubt in part because of fears the poor would not, or could not, be prudent buyers. Whether such paternalism has been justified or not, under a properly functioning NHCT plan the medically indigent family would have an official ombudsman in the form of the trust administrator, who is writing the checks and keeping tabs of the balances. A critical issue politically would be whether Phase I was deemed successful enough to lend credibility to this optimistic Phase II scenario about the TA and the medically indigent client.

The National Health Care Trust Plan would provide individuals with new incentives and equitable opportunities to provide for their own health and social welfare over an ever-lengthening life-cycle. In the process, the NHCT plan would set medical care spending—particularly long-term care spending—on a new moral footing. In effect, it clarifies the
social contract. Under the NHCT plan, government will always be there, as “the enforcer” to expose and punish TAs and providers that do not play by the agreed-upon rules, and as the “keeper of the flame” for distributive justice via the basic grants mechanism. But in the long run, under the NCHT plan, it is the citizens who will determine how much to allocate for long-term care.

NOTES

1. For a detailed exposition of prominent market strategies, see Alain C. Enthoven, Health Plan: The Only Practical Solution to the Souring Cost of Medical Care (Reading, Mass.: Addison-Wesley Publishing Co., 1980); Paul M. Ellwood and Walter McClure, Health Delivery Reform (Excelsior, Minn.: InterStudy, 1976); and Clark C. Havighurst, Deregulating the Health Care Industry: Competition and Health Planning (Cambridge, Mass.: Ballinger Publishing Co., 1982).


3. An exception might be provider groups that calculated they would prosper, relatively, in a more competitive environment (for example, for-profit hospitals).


7. U.S. Chamber of Commerce, Clearinghouse on Business Coalitions for Health Action, Coalition Report (January 1985): 6. This continuing growth in employer liability for the post-65 population is due not only to many firms having previously committed to help pay the health costs of retirees (over and above Medicare), but to legislative changes in the past three years that together increased employer responsibility for the elderly who continue to work. Amendments in 1982 to the Age Discrimination in Employment Act required most firms offering health insurance to also cover workers aged 65 to 67. The 1982 Tax Equity and Fiscal Responsibility Act required such employers to be the “first payers” for these employees (with Medicare generally being the second payer). The Deficit Reduction Act of 1984 extended this by requiring employers also to be first payer for these employees’ Medicare-eligible dependents. See U.S. Small Business Administration, The State of Small Business: A Report to the President (Washington, D.C.: Government Printing Office, May 1985), 275; and Employee Benefit Research Institute, “Financing the Elderly’s Health Care: Private Options and Public Policy,” mimeograph, Washington, D.C., 1984.


15. Clark et al., *Inflation*.


18. The effective guarantors of such inflation-proof benefits would be employers who would have to make up annually any difference between their payout liability to retirees and the pension asset income normally earmarked for this purpose (Munnell, *Private Pensions*).


29. In a communication to the authors, Charles Phelps has argued that making HCTA ownership family-based rather than person-based “reeks of danger.” He is especially concerned about complications arising from lengthy divorce suits, common law marriages, and the fluctuating composition of many households. His points are well-taken. But the “family” does, in a sense, have an administratively viable definition in the context of community property laws and jointly filed income taxes with dependent

30. "In a communication to the authors, Charles Phelps has argued that making HCTA ownership family-based rather than person-based “reeks of danger.” He is especially concerned about complications arising from lengthy divorce suits, common law marriages, and the fluctuating composition of many households. His points are well-taken. But the “family” does, in a sense, have an administratively viable definition in the context of community property laws and jointly filed income taxes with dependent
deductions, for example. Still, it would be instructive, at least, to reformulate the NHCT plan on a per person basis.

30. We are indebted to Michael Bromberg and Samuel Mitchell for the idea of encouraging the purchase of catastrophic coverage through such a contingency mechanism.

31. Families selecting coverage option (1) who wished to qualify for the HCTA earnings tax break would merely need to select a policy that included the out-of-pocket expense ceiling among its provisions.

32. Enthoven, Health Plan. Per capita expenditure savings of 25 percent or more have typically been found, most often attributed to reduced hospital expenses through lower admission rates.


35. The larger the volume of HCTAs the TA manages, the greater its capacity for risk-pooling and the smaller the fraction of total HCTA assets it would need to keep liquid in order to cover ongoing medical disbursements. In addition, many TAs—especially smaller ones—would probably choose to have “stop-loss” insurance to cap their annual medical payouts and thus prevent a run on invested funds.

36. We propose that the Federal Deposit Insurance Corporation, or similar government entity, insure each HCTA balance up to some maximum amount (e.g., $50,000) that guarantees adequate liquidity to meet family medical expenses for some reasonable period of time, regardless of the condition of the TA’s portfolio. In general, these portfolios would be regulated like other private pension funds under provisions of the Employee Retirement Income Security Act (ERISA) of 1974. Trust administrators would be subject also to state banking and insurance laws.

37. The mechanisms under the National Health Care Trust Plan for cost control with quality assurance rely on a structure of mutually reinforcing incentives imposed upon actors who occupy “friendly adversarial” positions. For this reason we would not permit provider organizations either to become, manage, or have a financial interest in a trust administrator. In the NHCT plan, each provider already has economic incentives to control costs; to permit the provider also to profit from the investment returns on these cost savings is to tilt the system uncomfortably in the direction of long-term HCTA growth at the expense of medical care quality assurance in the preretirement years.

38. Trust administrators may recognize incentives to undertake an additional information provision role. With data on new technologies burgeoning even while information on current practices remains under-analyzed and under-disseminated, there is a need for more efficient, two-way communication between researchers and practitioners. Trust administrators, would have a strong incentive to estimate—and to pass along to HCTA owners and their providers—just how much health status improvement is being purchased with HCTA dollars. The individual TA could easily enough handle the distribution of such clinically related information, but its production would require resources, and also benefit from scale economies, not generally available at the individual TA level. However, one can envision a consortium of TAs, possibly with federal or private foundation support, undertaking cost-effectiveness studies in clinical areas where the stakes, either in costs or health status terms, are considerable.

39. In February 1984, the Internal Revenue Service ruled that such flexible spending accounts were illegal under IRS Code Section 61. “Under these arrangements, employees submit proof of their expenses to their employer, who recharacterizes a portion of the
employees’ otherwise agreed-upon salary as ‘reimbursement’ for such expenses. The arrangements are merely attempts to pay taxable compensation without compliance with the federal tax laws, by labeling a portion of the employee’s salary as ‘reimbursement,’” the agency said (see IRS, New Release IR-84-22, 10 February 1984). This ruling did not invalidate the general concept of cafeteria-style benefit plans, as defined broadly in Code Section 125, nor did it place new limitations on the amount of employer contributions to these accounts. But it did assert—and this is crucial, we think—what has become known as the “use it or lose it” provision. Essentially, the employee must decide, before the beginning of each year, the expenditure ceiling applicable to each benefit on the menu of his/her cafeteria plan. “Under these plans, if the employee elects reimbursement [in a benefit category], but incurs such expenses during the year in an amount less than the limitation, the employee receives no further benefits or payments of any kind,” the IRS wrote. Except to exempt some firms with such plans from retroactive penalties, Congress essentially sustained the IRS’s position in the Deficit Reduction Act of 1984.

To see the implication of this interpretation, consider the case of an employee in a cafeteria plan who must decide ahead of time between two health insurance options, both fully paid for by the employer (in pre-tax dollars): option A, a comprehensive coverage plan requiring minimal cost-sharing and costing $2,000; and option B, with fewer benefits, a higher deductible, and cost of $1,000. While it is true that if the employee elects option B, much or all of the $1,000 difference could be reallocated, in principle, to other benefit categories in the cafeteria plan before the year starts, it is not clear at all the employee will regard this as the rational choice. Medical expenses represent both the largest and most unpredictable item on the cafeteria menu. If the employee elects option B and major illnesses arise, there will be significant out-of-pocket expenses, which, under the IRS interpretation, must be borne in after-tax dollars; money initially set aside for legal services or retirement savings cannot be reallocated to plug the gap. Thus, the risk-conscious employee generally would have the incentive to elect option A to hedge against the distinct possibility of significant, unplanned outlays.

Now under the business community’s original interpretation of flexible spending accounts (and prior to the IRS ruling), the employee could offset some or all of these noninsured medical expenses under option B with other funds residing in the spending account. Thus, the employee could choose option B and know that if disaster did strike, the out-of-pocket cost burden could be partially defused. Further, under the firms’ interpretation, the $1,000 premium difference could not only be allocated to other benefits in the current year, it could either (1) be paid as taxable income at the end of that year, or else (2) be “rolled over” to future years in order to accommodate natural but unforeseen fluctuations in the family’s service demands. Conversely, the allocative inflexibility inherent in the IRS’s “use it or lose it” interpretation acts as a double-edged sword to thwart incentives for medical cost-containment (directly) and retirement savings (indirectly). On the one hand, it dilutes the value of the cost savings an employee realizes from choosing B rather than A by requiring, in essence, that the premium difference be allocated precisely to other benefit categories in the current year before the service demands in those categories (such as legal services) can be known precisely. If the employee underestimates, the expenses, or otherwise attempts consciously to economize, in a given spending category, he/she reaps no resulting financial benefit. Indeed, the incentive is to spend up to the limit in every fringe benefit category once the initial allocations are set.

41. See, for example, the statement attributed to Robert J. Rubin, former Assistant Secretary of Health and Human Services in Milt Freudenheim, “New Employer Health Plans Give Cash for Unused Benefit,” New York Times, 30 May 1984, p. 9.
44. Ibid.
46. In the EBRI survey, 14 of 20 surveyed firms with flexible benefit plans offered employees the 401(k) capital accumulation option, and 16 offered FSAs that included at least health care. But in no case in the survey did a flexible spending account include only the 401(k) option and health care.
50. For a review of Reagan administration proposals see: Spencer Rich, “Plan Would Cut U.S. Share of Health Cost,” *Washington Post* (1 February 1983) 1; Office of the Secretary, Department of the Treasury, *Tax Reform for Fairness, Simplicity, and Economic Growth (The Treasury Department Report to the President)* (Washington, D.C.: U.S. Government Printing Office, November 1984); and The President’s *Tax Proposals to the Congress for Fairness, Growth, and Simplicity* (Washington, D.C.: U.S. Government Printing Office, May 1985). The recommendation in the latter to tax “first-dollar” contributions toward the purchase of health insurance would almost certainly generate extra federal revenue since very few persons will reduce their health insurance purchases as a result of this tax. By the same token, it does nothing to discourage the purchase of expensive, deep coverage plans, since the premium differences between a firm’s low cost and higher cost plans could be paid in pre-tax dollars in virtually all cases; this, of course, becomes identical to the current arrangement.
53. *President’s Tax Proposals for Fairness, Growth, and Simplicity*.
54. There are a number of institutional distinctions between the NHCT plan and the Danne-meyer plan, but perhaps the most major difference is that the latter does not intend to deal with problems of the medically indigent. There is no counterpart in H.R. 1791 to the basic grant; Medicaid in its current form is implicitly assumed.