Reforming Health Insurance: Realistic Options And Hard Choices

The degree of government regulatory control remains a stumbling block to consensus on how to insure more Americans.

by Joseph R. Antos

ABSTRACT: The persistently high number of people reporting that they have no health insurance has precipitated a number of new comprehensive proposals to extend coverage to most Americans. Such proposals must find solutions to fundamental problems that have thus far eluded policymakers, including the role of government regulation, how much to spend, and who should pay. The experience of the 1990s suggests that an effective policy would offer more choices of health plans through the private market, limit unnecessary government regulation, and provide appropriate subsidies to individuals.

The U.S. economy enjoyed unprecedented growth over the past decade. Between the start of the economic boom in 1991 and the onset of recession in 2001, gross domestic product (GDP) grew by $4 trillion. By the end of that decade more Americans had jobs than at any other time in history.

However, the good news was not reflected in the health sector. Instead, the number of uninsured people increased slowly but persistently over most of the decade. That number dropped in 1999 but has since returned to its upward trajectory. An additional 5.8 million people were counted as uninsured by the end of the ten-year economic expansion.

That disappointing performance precipitated a failed attempt to reform the health system by the Clinton administration and subsequent smaller steps to increase insurance coverage, including the creation of the State Children’s Health Insurance Program (SCHIP) in 1997. Calls for broad new solutions for the uninsured are again emerging on the political scene, including an employer mandate from Sen. Ted Kennedy (D-MA) and an individual mandate from Sen. John Breaux (D-LA).1

Karen Davis and Cathy Schoen provide a detailed plan for achieving universal coverage that they believe could create consensus among policymakers. The Davis-Schoen proposal has some attractive features, including an expansion of consumer choice and individual tax credits to subsidize the purchase of insurance. Consensus is building that consumers should be given realistic health plan options as a way of increasing the value of their health care dollars. But the proposal’s rigid regulatory structure and major redistribution of financial responsibilities are major barriers in the way of political compromise.

We face a real dilemma. Incremental pol-
cies that simply build on current models for obtaining and financing health insurance are unlikely to solve the problem of the uninsured, even in the best of circumstances. Stronger measures might be more effective, but such approaches are less likely to be adopted. Policymakers and the public have demonstrated a strong aversion to major reforms—particularly reforms that require everyone to change the way they buy insurance. In either case, policymakers will be forced to make hard choices on fundamental issues, including whether the regulatory role of government should be expanded, or whether private market forces should have a stronger role in managing health care; whether a mandate should be imposed to require insurance coverage, and, if so, whether the mandate should be on individuals or employers; how much should be spent to subsidize new insurance coverage; and who would (or should) win and who would lose under the new policy.

Lessons From The Economic Boom

The period of general economic expansion between 1991 and 2001 saw large increases in national spending for health services. Over that period total spending for health services grew from $735 billion to $1,373 billion (Exhibit 1). Health care spending by all levels of government doubled and accounted for about 45 percent of the total by 2001. Private insurance spending also doubled. Out-of-pocket and other private spending grew more slowly, increasing by about half over that period.

Those spending increases were accompanied by shifts in the source of insurance coverage. Government insurance programs grew modestly, with enrollment increasing by 7.4 million between 1991 and 2001. Almost 60 percent of that increase occurred between 2000 and 2001, when the economy was beginning to show some signs of softening. In contrast, private insurance grew strongly during the decade, with a shift away from coverage in the individual market. Employment-based group coverage grew by 26.5 million over the decade, while individually purchased insurance fell by eight million.

The growth of employment-based insurance reflects both favorable tax treatment, which lowers the worker’s net cost of coverage, and pressure from tight labor markets, which pushed up the total compensation of many workers. In addition, the range of insurance options available to workers also expanded, allowing many to obtain plans that better matched their preferences and demand for health services.

Employer contributions for health benefitsOTHER PRIVATE

EXHIBIT 1
National Spending For Health Services And Health Insurance Status, 1991 And 2001

<table>
<thead>
<tr>
<th></th>
<th>1991</th>
<th>2001</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending on health services (billions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>$305</td>
<td>$ 613</td>
<td>$308</td>
</tr>
<tr>
<td>Private insurance</td>
<td>254</td>
<td>496</td>
<td>242</td>
</tr>
<tr>
<td>Other private</td>
<td>176</td>
<td>263</td>
<td>87</td>
</tr>
<tr>
<td>Total</td>
<td>735</td>
<td>1,373</td>
<td>638</td>
</tr>
<tr>
<td>Health insurance status (millions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>63.9</td>
<td>71.3</td>
<td>7.4</td>
</tr>
<tr>
<td>Individual insurance</td>
<td>31.3</td>
<td>23.3</td>
<td>–8.0</td>
</tr>
<tr>
<td>Employment-based insurance</td>
<td>150.1</td>
<td>176.6</td>
<td>26.5</td>
</tr>
</tbody>
</table>


NOTE: Spending components do not add to total because of rounding.
are excluded from the worker’s taxable income. Thus, the net cost to workers of employment-based coverage is well below the cost of equivalent coverage in the individual market. The Office of Management and Budget (OMB) estimates that the exclusion of employer health insurance contributions resulted in forgone federal tax revenues of nearly $83 billion in 2001. If those employees were given the equivalent subsidy in the form of a cash grant that was fully taxable, federal outlays would increase by nearly $107 billion. These estimates understate the full impact of the tax exclusion, since they do not include reductions in payroll tax and state income tax revenues.

Tight labor-market conditions caused many employers to raise the compensation they paid to their workers to reduce the chance that workers would be lured away by a competitor. Because of the tax advantage, better health benefits were part of the pay increase. Many employers absorbed more of the cost of health insurance premiums, which held down increases in premiums paid by employees.

The mix of plans offered by employers also broadened over the decade. Enrollment in conventional indemnity insurance fell sharply as employment-based insurance shifted to health maintenance organizations (HMOs) in response to rising health costs. But the shift to managed care reversed in the mid-1990s with the tightening labor market, rising wages, and a pushback against tightly managed care. Employees increasingly moved to preferred provider organizations (PPOs) and plans offering a point-of-service (POS) option, which offer lower premiums than an indemnity plan but more flexibility than an HMO. By 2001 such plans accounted for 70 percent of health plan enrollment by covered workers.

Several broad conclusions can be drawn from the experience of the 1990s that should be heeded in the coming policy debate. First, people want more control over their health care and are willing to accept realistic options to achieve that objective. Greater control means that they can choose their own doctor and have more say in their treatment. A broad choice of health plans—spanning the range from traditional indemnity coverage to tightly managed health plans, and from plans offering high-deductible insurance with a medical savings account to plans offering more conventional benefits—would allow people to decide for themselves how much control they want and how much they are willing to pay for it.

Second, the private market responds quickly to economic incentives. Changing consumers’ preferences for lower cost versus greater control over health care quickly translated into more flexible plan choices. As in other private markets, health plans that adjust to changes in consumer demand increase their market share.

Third, tax incentives are a powerful tool in promoting health insurance coverage. Such incentives have been the major force in the expansion of employment-based insurance, and they could be extended to people buying coverage in the individual market. Analysis by Mark Pauly and Bradley Herring suggests that a tax credit covering half to two-thirds of the cost of premiums could cut the number of uninsured people in half.

Fourth, a highly regulatory system is not the answer. A balance must be struck between providing essential consumer protections and imposing unnecessary and harmful limitations on consumers and health plans. Requiring a rich minimum benefit package, as proposed by Davis and Schoen, runs the risk of imposing unaffordable expenses on consumers and taxpayers. Rate regulation can stifle competition and result in higher rather than lower costs. Mandates on individuals to buy insurance are difficult to enforce and would be unnecessary if the uninsured were given appropriate health
plan choices and financial incentives to purchase coverage, such as tax credits.

Fifth, health insurance is only part of the solution. Health insurance reduces financial barriers to the use of health services. But having an insurance card does not necessarily mean that a person will seek or be able to get appropriate care. And some will not enroll even if it does not cost them anything. Other policies, including expanded support for clinics and community services, can be important in addressing the broader issue of public health.

**Hope Of Consensus?**

The onset of an economic turndown has raised concerns that the employment-based health insurance system might weaken just as governments at all levels are facing rising fiscal pressures. Under those circumstances, we are not likely to see much enthusiasm on the part of taxpayers, employers, state governments, or the federal government to shoulder a much larger financial burden.

Any reform that greatly increased the number of people with insurance would require increased spending. Even if we could agree on a dollar figure, we must still resolve the sharp disagreement over the degree of government control in a new system. Congress has been grappling with those issues in the context of a Medicare prescription drug benefit. Broader system reform awaits the outcome of that debate.

**NOTES**

1. The Economic and Social Research Institute (ESRI) has assembled a wide array of comprehensive proposals to extend health coverage to most Americans. See J.A. Meyer and E.K. Wicks, eds., *Covering America: Real Remedies for the Uninsured*, vols. 1 and 2 (Washington: ESRI, 2001 and 2002).