



A VISION FOR CONSUMER- DRIVEN HEALTH CARE REFORM

**A statement of
principles and
recommendations
by leading health
care economists
and health policy
analysts to guide
health care reform**

HEALTH POLICY CONSENSUS GROUP

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The Health Policy Consensus Group is a task force of leading health care economists and health policy analysts, including researchers at the major market-oriented think tanks. The Consensus Group is working to increase public awareness that the tax treatment of employment-based health insurance underlies many of the problems facing the public health sector in the United States.

The incentive-based reforms the group proposes are intended to strengthen and rationalize the health care market. The Consensus Group believes that the competitive market is the most appropriate way to restrain costs and to give Americans more responsibility and opportunity to choose their health insurance and health care arrangements.

The group considers different approaches to reform and provides education on their benefits and disadvantages to help the public and policymakers understand the balances that must be struck in any reform effort. Members have been working together to provide policy advice since 1993. The group endorses basic principles but does not offer specific legislative proposals. The Galen Institute, a not-for-profit health and tax policy research organization, coordinates and facilitates the work of the Consensus Group.

These ideas are based upon many meetings and exchanges of information by members of the Consensus Group, who are listed as signatories at the end of this booklet. The views expressed in this document reflect those of the individual signers and not necessarily their organizations. Grace-Marie Arnett, president of the Galen Institute, and John S. Hoff, health care attorney and Galen Institute trustee, were the principal writers for this vision statement.

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OVERVIEW

The United States does not have a properly functioning market for health care, and the financing system needs to be reformed. The market is distorted by a tax policy that is mistargeted, miscalibrated, and open-ended. This tax policy provides generous benefits to those who have higher incomes and receive health insurance through the workplace. Yet it offers little or no assistance to those at the lower end of the income scale. Particularly at a disadvantage in the current system are those who fall through the cracks between this tax subsidy and Medicaid.

Reforming the tax treatment of health insurance is essential to creating a more efficient and equitable market for medical services and health insurance in the United States. Correcting the tax distortion would lower the costs of health insurance coverage in both the public and private sectors and thereby allow broader access to quality health care.

This booklet describes the Consensus Group's vision for consumer-driven health care reform based upon tax reform. These principles and recommendations are integral to the market-based proposals for health care reform of each of the health policy experts in the Consensus Group. There is unanimous agreement on the nature of the problem, and consensus on direction indicated by the recommendations for reform.

THE PROBLEM: A RICH BUT HIDDEN TAX SUBSIDY FOR EMPLOYMENT- BASED HEALTH INSURANCE

THE HISTORY

Early in the 20th century, the link between health insurance and the workplace began to be established in the United States. During and after World War II, however, employment-based health insurance became more widespread, and the link became stronger.

Factories were pushed to meet wartime production schedules. Competition for good workers was intense but was hampered by wartime wage controls. Employers found they could compete for scarce workers and boost compensation without running afoul of these controls by offering health insurance as a benefit in lieu of cash wages. In 1943, the Internal Revenue Service ruled that employers' contributions to group health insurance would not count as taxable income for employees.

That ruling, a later codification of it by Congress in 1954, rising tax rates on middle class incomes, and the rising demand for health insurance all combined to create a strong incentive for health insurance to be obtained through employment-based groups.

The generous tax preference accorded job-based health insurance is a historical accident that has increased automatically over the decades without legislative authorization or appropriations. It has percolated through the economy for 50 years to become the foundation for a system that provides subsidies and therefore strong incentives for at least 150 million Americans to get their health insurance through their jobs. The subsidy for employment-based health insurance now is worth an estimated \$125 billion a year in forgone federal taxes.

HOW THE TAX SUBSIDY WORKS

The tax code offers an exclusion from taxable income to those who get their health insurance at work.

Employment-based health insurance is part of the compensation package many employers provide to their employees—a form of non-cash wage.

Employers can take a tax **deduction** for the cost of this health coverage, as they do for most other forms of employee compensation. They write the check for the premiums, and some pay medical bills directly if they self-insure. Businesses can deduct these costs from their earnings since they are part of the total compensation package paid to workers and must be deducted to measure net profits correctly.

What makes health insurance different from cash wage or salary compensation, however, is that workers **do not pay taxes** on the part of their compensation package they receive in the form of health benefits.

Section 106 of the Internal Revenue Code provides that the value of health benefits is not counted as part of the taxable income of employees—in tax terminology, it is **excluded** from their taxable income. However, workers may receive this tax-favored benefit **only** if health coverage is provided through an employer. The value of the health coverage, the tax benefit employees receive, and the costs in forgone wages are largely invisible to them.

HOW IT DISTORTS THE HEALTH CARE MARKETPLACE

Tens of millions of Americans receive little or no benefit from this rich but hidden tax subsidy. In addition, it distorts the health care marketplace in a number of ways:

- It undermines cost consciousness by hiding the true cost of insurance and medical care from employees.
- Because the full cost of health insurance is not visible to employees, it artificially supports increased demand for covered medical services and more costly insurance.
- As a result, inefficient health care delivery is subsidized at the expense of efficient delivery.
- Cash wages are suppressed.
- Many employees with job-based coverage are frustrated because they have little choice and control over their health insurance and their access to medical services.
- The tax benefits are skewed to favor higher-income individuals and those who demand the most expensive health coverage and medical treatments.
- Those with equal incomes are taxed unequally.
- The self-employed, the unemployed, and those whose employers do not offer health insurance are discriminated against because they receive a much less generous subsidy, if any at all, when they purchase health insurance.

WHAT CAN BE DONE?

This Vision Statement provides guiding principles for reform, specific recommendations for change, and guidelines to achieve greater equity and efficiency in the health sector, leading to more affordable, accessible health insurance

GUIDING PRINCIPLES OF CONSUMER-DRIVEN REFORM

The following are guiding principles to assist policymakers and the public in making key decisions to achieve a true consumer-driven health care system.

CONSUMER CHOICE. Individuals should have choices in the medical care and health coverage they obtain, whether they secure coverage as individuals or through their employers or other groups. Government policies should expand the opportunities for individual choice without dictating or distorting these choices.

COMPETITION. Consumers of medical services will receive the best value when providers are competing to offer the best price, quality, and services. Therefore, the system should rely on market competition, not government regulation or price controls, to promote efficiency, quality, and value.

RESPONSIBLE BUDGETING. Government incentives to help targeted populations obtain private health coverage should be explicit, on budget, and reviewable.

FIXED AND LIMITED INCENTIVE. Individuals and families with the same incomes should receive the same assistance when purchasing health insurance, regardless of their employment status or whether their employers offer health insurance. Individuals should not be able to increase their claim on taxpayer revenues by purchasing more health coverage.

EXPANDED ACCESS. In a market based upon consumer choice, a more attractive range of options for health coverage will be available to a wider range of people, including those currently without health insurance. Once the market is functioning more efficiently, it will be clearer whether further legislation is needed to enhance people's ability to secure health coverage.

RESPONSIBLE INSURANCE. Health coverage should provide, at minimum, protection against catastrophic loss—namely, high-cost, low-probability medical events. The tax system has encouraged movement away from this basic principle of insurance. Instead, health coverage has become a way to pre-pay routine medical bills. A first step toward reducing the number of Americans without health insurance is to return to the principles of insurance and thereby protect against large expenses in the event of catastrophic medical events.

PUBLIC-SECTOR CHOICE. Given the rapidly rising costs in federal health care programs, especially Medicare and Medicaid, the federal government should make full use of private-sector competition to control costs by giving beneficiaries more options to participate in the private market.

COST AWARENESS. Programs that enhance individual purchasing powers will be more efficient because costs will be more visible to consumers. Programs and plans that make payments directly to providers insulate consumers from costs, artificially increase demand, and distort the health care marketplace.

FULL INFORMATION. Employers who provide health insurance should periodically inform their employees about how much of their compensation is being spent on health benefits and that this spending has reduced their cash wages by a commensurate amount.

COMMUNITY VERSATILITY. The strength, diversity, and vitality of private-sector community organizations are an important resource in the health sector. Communities should experiment with public-private partnerships and other solutions for providing health care to low-income citizens, utilizing local resources to solve unique community problems.

GROUP PURCHASING. Tax and regulatory barriers to creating competitive private health care purchasing groups should be eliminated. Barriers to the creation of innovative provider groups should also be eliminated.

VALUE. As a result of implementing these principles, consumers will obtain better value for their health care dollars. The price system will convey consumers' needs and demands. Competition will facilitate more efficient use of technology and continued innovation in products and service delivery and will reduce waste and duplication.

RECOMMENDATIONS FOR CHANGE

The following are policy recommendations of the Consensus Group. These recommendations and the principles upon which they are based can provide a powerful guide for the policymaking process in achieving important goals of health care reform. They are not intended to provide a complete blueprint for reform, and reasonable men and women may differ over the details of how they should be implemented.

We believe that following these recommendations will lead to a system in which costs will be restrained, private insurance coverage will expand rather than continue to contract, and quality will be enhanced primarily through additional competition and better consumer incentives.

THE BASIC GOAL

Every American should be able to obtain needed medical care. Reforming the tax treatment of health insurance is central to achieving this goal.

Congress could begin by **providing a new set of incentives** for people who do not have health insurance. These incentives should be properly structured to create an opportunity for everyone to purchase his or her own health coverage in an open and competitive market.

THE PRINCIPLED, RESPONSIBLE ALTERNATIVE

We recommend providing credits or other comparable fixed incentives, explicitly determined by legislation, to assist people in obtaining private health insurance.

The size of the incentives will depend on how much taxpayer money lawmakers deem to be available. It can be structured in different ways.

OPTIONS

- Credits or other fixed incentives could be used to purchase private group or individual health coverage, in combination with medical savings accounts for those who choose them.
- If tax credits are provided, they could be refundable, over and above the Earned Income Tax Credit.
- The size of the credit or alternate financial incentive could be adjusted to reflect risk or need, or it could be used to buy into a high-risk pool. These adjustments should be made while minimizing their effect on marginal tax rates.
- To expand access to coverage, state mandated benefit laws could be preempted for insurance purchased with federal assistance, thus allowing a broader range of more affordable insurance products.

BENEFITS OF THIS APPROACH

- Millions of Americans not eligible for the current tax subsidy would receive help in purchasing health insurance.
- Assistance can be targeted to those who do not have health insurance.
- It can be targeted to those in specific age, income, or other categories which legislators deem most worthy of the assistance.
- It gives individuals more choice as to where they obtain health insurance.
- It allows individuals the opportunity to select the kind of health coverage that best suits their needs.
- It helps to minimize distortions in the marketplace
- It is more equitable across income groups.
- The subsidy does not expand when an individual purchases more expensive insurance.
- It is available whether an individual's insurance is organized through employment-based groups or elsewhere. The role of employers in assisting employees to obtain health insurance could be maintained by each employer, if the company so desired.

KEY DECISIONS

Some of the many questions that must be addressed:

- How much money should the federal government spend on the incentive?
- How much will it be worth, to individuals and families?
- Who will be eligible?
- Does the amount vary with income?
- How will risk adjustments be structured to keep policies affordable?
- How does one define what level of coverage must be purchased to qualify for the assistance?
- How will compliance be monitored and enforced?

GUIDELINES FOR A MORE EFFICIENT AND EQUITABLE SYSTEM

The following guidelines will help lawmakers in making policy decisions about reforming the tax treatment of employment-based health insurance to promote a more efficient market in the health sector.

1. Incentives for purchasing health insurance should be provided directly to individuals and families.

2. This assistance could be in the form of credits or other incentives to be used to purchase medical services or health coverage. Employer groups are efficient mechanisms for the pooling of risk, and some proposals would have employers offer plans on which the individual credit could be spent. However, the money also could be used to obtain coverage in a variety of other ways, either individually or through participation in groups, such as health plans sponsored by unions, trade or fraternal organizations, schools, or churches.

3. Incentives for purchasing health coverage or medical services should not be provided through open-ended tax preferences or defined in terms of covered services, but rather should be limited to a fixed dollar amount, which could be adjusted over time through legislation and also adjusted by an individual's income and risk factors.

4. To eliminate the distortions in the current system and to provide even broader access to coverage, policymakers should consider capping or eliminating the tax exclusion for employment-based health benefits. By simultaneously providing offsetting assistance to individuals, the changes we recommend need not result in an increase in the tax burden for the American people and could even reduce taxes.

5. In view of concerns about the complexity of the income tax system, it should be noted that there are alternative administrative options available and that there is no necessary conflict in theory or in practice between the provision of a health care incentive and simplification of the income tax. The incentive could take many forms: direct assistance which is administered through a stand-alone outlay program or as part of other incentive programs; in conjunction with the payroll tax; or, as now, via the income tax.

6. Health insurers and health plans should have the flexibility to offer rewards and incentives for healthy lifestyles.

7. Reform of the Medicare system should expand private-sector options for beneficiaries. Medicare benefits should be defined in terms of a risk-adjusted dollar amounts, not in terms of an open entitlement to covered services.

8. Beneficiaries should be able to elect to participate in traditional Medicare or to privately purchase health coverage or medical services of their choice.

9. Medicaid beneficiaries should be incorporated into the private health care system envisioned by these principles. Beneficiaries also should be able to purchase health coverage through the private sector. Just as with Medicare, Medicaid benefits should be defined in terms of a dollar amount, not an open entitlement to covered services.

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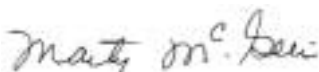
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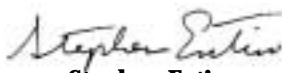
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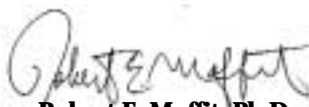
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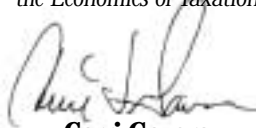
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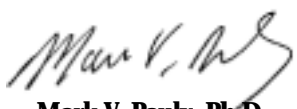
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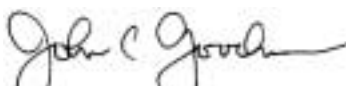
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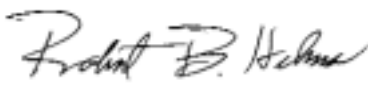
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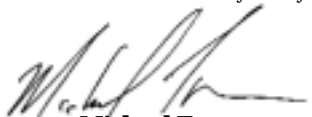
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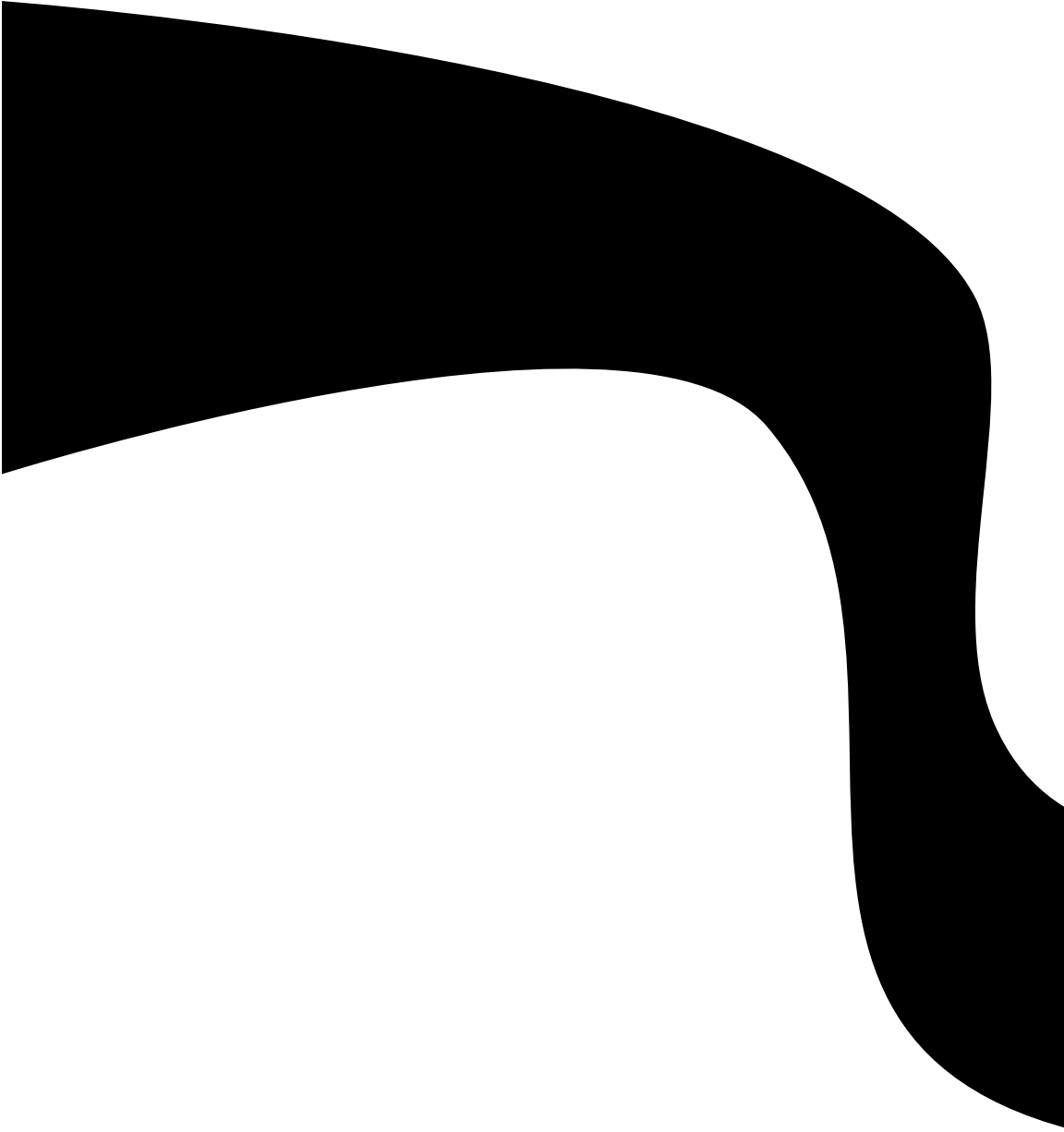
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