The Heritage Foundation Backgrounder

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USING TAX CREDITS TO CREATE AN AFFORDABLE NATIONAL HEALTH SYSTEM

INTRODUCTION

Demands are growing for reform of America's health care system. To be sure, the quality of care available in the United States surpasses that of any other nation. Still, as many as 37 million Americans are without health insurance during at least part of any year. Millions more have insurance that pays for routine care, but would not cover the catastrophic financial impact of a prolonged, serious illness.

Even those with adequate insurance provided through their place of work face increases in out-of-pocket charges, or cutbacks in coverage for family members, as employers try to contain surging insurance costs. Insurance companies complain that physicians persistently order unnecessary tests and procedures. Physicians complain that insurance company officials are interfering with the practice of good medical care. The result: a $600 billion health care system with which nobody, it seems, is happy.

Disenchantment with the system has spawned several high level government task forces and commissions charged with finding ways to improve U.S. health care. The ideas being considered by these bodies are in three broad categories:

- **Social insurance** programs, based on the Canadian system. These would provide every American with universal access to a comprehensive package of health services, dictated and paid for by government and financed through taxation.

- **Employer mandates.** These would require all employers either to provide at least a standard package of health insurance to employees and their

families, or to pay into a fund to finance insurance for families not covered at the place of work. This often is referred to as the "play or pay" approach.

♦ **Consumer-based systems. In these, changes in the tax treatment of health care purchases would provide families with the funds to buy adequate insurance and medical care directly, rather than depending on their employer or a government program. Such a consumer-based proposal was unveiled last year by The Heritage Foundation.**[1]

In the vigorous debate between proponents of these rival proposals, questions are raised about each approach. Close examination of the Canadian system, for example, reveals not only that it holds down health costs by systematically rationing care, but also that costs have been controlled far less than commonly believed.[2] Similarly, the mandated employer benefits proposal has encountered strong opposition from businesses, who claim that it rapidly will escalate company health costs, prompting layoffs and undercutting U.S. global competitiveness.

Concerns also have been raised regarding the Heritage Foundation proposal. Examples: Are families typically capable of making informed decisions when purchasing health insurance or medical services? Would not insurance companies tend to compete only for healthy families needing fewer services, leaving higher risk families with enormous premiums to pay? Would Americans accept such a seemingly radical change in their health care financing system?

While these and others are legitimate concerns, they are fully addressed in the Heritage proposal. Indeed, the Heritage proposal is the only one advanced to date that would assure affordable access to health care for all Americans with little or no additional cost to the federal Treasury and with built-in, market-driven incentives to keep costs under control.

THE GOALS OF HEALTH CARE REFORM

While there are differences of opinion on the details of what an ideal health care system would achieve, four features are broadly accepted as goals of such a system:

1) The system should assure affordable access to adequate health care for all Americans.

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1 . Stuart M. Butler and Edmund F. Haislmaier (editors), *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); see also Butler, "Assuring Health Care for All Americans," *Heritage Lectures* No. 218, October 2, 1989.

2 Michael Walker, "Why Canada's Health Care System Is No Cure for America's Ills," Heritage Foundation *International Briefing* No. 19, November 13, 1989.

The notion that all citizens should be able to obtain adequate health care services at reasonable cost to the family budget is the central feature of most Americans' picture of an ideal system.

2) The system should contain incentives to economize.

The rapidly rising cost of today's health system has led lawmakers to insist that any serious reform must contain strong incentives to economize and keep costs under control—without cost becoming a barrier to necessary care.

3) Government help should go mainly to those who need it most, as measured by income or medical condition.

Many socialist countries base their health systems on the doctrine that government should provide the same quality and quantity of care to rich and poor alike. In the U.S., however, it is generally accepted that the more needy a family is, in terms of the cost of necessary medical care compared with the family's income, the more governmental help that family should receive.

4) As far as possible, crucial medical decisions should be made by the patient and his or her physician.

In addressing such basic medical questions as whether a major operation shall be performed, or who shall perform that operation, or how much shall be done to save a baby born prematurely, most Americans feel that these decisions should be made as much as possible by the individuals directly concerned. It is they, it is broadly believed, who should have the right to weigh the benefits and the risks, with proper medical advice and with some attention to the costs involved. These decisions are not to be left to some distant official whose life is not on the line.

Why the Current System Does Not Reach These Goals

The current health care system does not achieve these or many other goals. Most of the uninsured, and even many of those with basic insurance, find they cannot afford certain necessary health services. Few would contend, moreover, that the current system promotes efficient use of medical services. It seems unfair to many Americans that affluent workers and top executives enjoy unlimited tax-free medical services through their companies, while low-paid workers in other firms have no company insurance, and get no help from the tax code to offset the cost of buying the most basic services or insurance. And there is growing anxiety that basic medical decisions are being made by distant government or insurance company officials, or in response to rules determined by such officials. Thus elderly Americans, for instance, fear they may be "dumped" by a hospital because the hospital considers the Medicare reimbursement rate to be too low; unionized workers strike against the attempts of company health benefits managers to limit coverage for families; mothers of newborn babies grumble that insurance companies refuse to cover more than three days in hospital after the birth.

These shortcomings of the system have a common root: the powerful, perverse incentives created by the tax treatment of health care spending. Under the federal tax code, company-provided health services and insurance plans are excludable from each worker's taxable income. For example, if a worker's compensation is an annual cash salary of $25,000 plus $3,000 in the form of a company-paid health plan, for a total of $28,000, that worker pays income and payroll taxes on only $25,000 of income. This makes the health plan, in effect, tax-deductible at the worker's marginal rate of tax. If the firm does not provide a health plan, however, the worker can only obtain tax relief to the extent that his family's health expenses exceed 7.5 percent of adjusted gross income, and then only if the family itemizes its tax return. Most self-employed individuals can claim tax relief on just 25 percent of their health insurance costs.

This tax treatment means that the lion's share of tax relief goes to higher-paid employees with generous health plans. Meanwhile, casual workers or those in small firms without plans, who tend to incur relatively high medical costs compared with their income, typically receive no tax relief at all. When these latter workers buy health insurance they must do so with after-tax dollars, and normally they must pay relatively high premiums for individual coverage. It is little wonder that so many of these workers and their families lack insurance.

"Free Fringe Benefit." The tax treatment of health spending also helps boost total health costs, encourages inefficiency, and provokes labor disputes. Company plans, for example, have grown rapidly in recent decades for understandable reasons: both management and labor have favored contracts that offer more compensation in the form of tax-free health insurance than in the form of taxable cash. This means that for most Americans, in terms of after-tax dollars, it costs less to buy health care than to buy other goods and services – even if both carry exactly the same price tag. The result: workers tend to demand far more, often non-essential, health services than they would choose were they to pay for them in after-tax dollars. In addition, many workers and their unions have pressed employers to include routine, minor services in health plans because that allows these services to be paid for with pre-tax dollars. By contrast, workers tend to be less inclined to press for insurance covering highly unlikely, but financially crippling, medical situations. Thus many American workers have very generous and expensive health plans, yet lack catastrophic insurance.

In the minds of most workers, these company-paid plans, like other fringe benefits, seem to be free – even though an employer rightly treats health insurance as part of the overall compensation. Thus there is little or no incentive for workers to curb their demands for health services or to question hospital or physician prices, especially if deductibles and copayments in the plans are small.

This has several effects. A lack of any real incentive to economize is, of course, a recipe for health care cost inflation, and indeed the cost of medical

care for years has been rising at roughly double the average inflation rate. This means, of course, higher prices for those who do not have company-provided insurance and consequently reduces their ability to obtain medical care. Meanwhile, corporate efforts to constrain rising health costs by increasing the employee's share of costs normally are strongly resisted by workers, who see these direct payments as a cut in pay, forcing them to pay in after-tax dollars for care that previously was "free." Bitter strikes over company attempts to scale back health benefits are an increasingly common feature of labor disputes.

Why Mandated Benefits or a Canadian System Is No Answer to These Problems.

Neither a mandate on all employers to "play or pay," nor a Canadian-style universal social insurance program would solve all these problems, or achieve the four basic objectives of an ideal health system. Moreover, in many important ways, each would be less attractive than America's current system.

Under employer mandates or a Canadian system the government would legislate a right of access to a certain level of health care, through the private sector in the first case and the public sector in the second. But to control total costs, various regulations would be imposed by bureaucrats to restrict that supposed right of access. Such regulation would be necessary because the illusion of virtually free care would encourage far more demand for services than companies or the government would be willing to pay.

Shortages and Rationing. Economists recognize that when services are free of change, or nearly so, and controls are placed on the total costs of providing the service, the result invariably is shortages and rationing. Recent studies of the Canadian system reveal that government cost control leads to rationing by waiting list and a pervasive system of physician price controls. This policy has limited significantly the availability of procedures and technology and has encouraged a rising number of Canadians to seek health care services in the U.S.

An employer mandate simply would shift the tab to business without correcting the underlying incentives that lead to the problems of the current system. Corporate health benefits managers would become the reluctant regulators of a business-financed national health service, caught between stockholders determined to check costs and employees with the legal right to demand services. Very likely the majority of frustrated employers eventually would follow the lead of some of today's business leaders who argue that corporations should not be expected to manage and finance a national health system, and that the job should be turned over entirely to government.

THE HERITAGE FOUNDATION PROPOSAL

Last year, The Heritage Foundation published a proposal to achieve universal access to affordable health care.[3] This proposal, unlike the Canadian system or mandated benefits, seeks to cool health care inflation and assure access by strengthening market incentives in health care and restructuring the tax treatment of health care spending. Specifically, the proposal calls for two major steps:

1) End the link between health care tax breaks and the place of work.

Under the Heritage proposal, the unlimited tax exclusion for company-provided health benefits would be phased out over several years. Thus, while companies could continue to provide benefits and count them as tax-deductible labor costs, the value of such benefits now would be included in the employee's taxable compensation. If the employer chose to reduce or eliminate the health benefits provided, he would be required by law to add the savings to each employee's paycheck so that the worker's total compensation would be unaffected.

Offsetting this change in the tax code, a new system of personal tax credits for family health spending would be introduced. Under this new arrangement, a family could claim a credit when filing its 1040 tax form. The credit would be available for both insurance and out-of-pocket costs. It also would be an "above-the-line" credit, so the family would not have to itemize its return to claim the credit. It would be refundable, meaning that if the credit exceeded the family's total tax liability, the taxpayer would receive a check for the difference from the IRS.

The credit would be based on the family's health and insurance spending compared with its income. Thus a 20 percent credit might be available in most instances, but may rise to 30 percent of medical and health insurance expenses if these costs exceeded, say, 5 percent of family income in a year; a 50 percent credit if spending reached 10 percent of family income, and so on. For very affluent families spending only a small proportion of their income on health, the percentage credit would be less than 20 percent, and perhaps phased out completely for those above a certain income.

2) Establish a "Health Care Social Contract."

The second central element in the Heritage proposal is a two-way commitment between government and citizen. Under this "social contract," the federal government would agree to make it financially possible, through refundable tax benefits or in some cases by providing access to public-sector health programs, for every American family to purchase at least a basic package of

3 Butler and Haislmaier, *op. cit.*

medical care, including catastrophic insurance. In return, government would require, by law, every head of household to acquire at least a basic health plan for his or her family. Thus there would be mandated coverage under the Heritage proposal, but the mandate would apply to the family head, who is the appropriate person to shoulder the primary responsibility for the family's health needs, rather than employers, who are not.

EFFECTS OF THE HERITAGE PROPOSAL

By no longer restricting tax relief for medical care to employer-provided plans, and by restructuring tax assistance to help those Americans most in need, the Heritage proposal significantly would improve the American health system. Among the most important effects:

1)Good health care not dependent on employers. Employees would be able to acquire health coverage for their families, and obtain government tax help to pay for it, wherever they happen to work. Casual or part-time workers, employees of small firms, or dependents of workers – those who comprise a major share of the uninsured – would receive a refundable tax credit based on health costs compared with income – exactly the same form of government assistance to buy health services as Americans working in large firms. Thus the Heritage proposal would solve much of the current uninsurance problem.

The Heritage proposal also would allow complete "portability" of a worker's health coverage, since it would no longer be tied to the place of employment. If a worker changes jobs, or has a spell of unemployment, he or she would not lose the insurance or have to change coverage, nor would his or her family face the possibility of exclusions for pre-existing conditions and similar insurance restrictions common today when a worker changes jobs.

2)Incentives to economize. Under the current system of employer-provided health benefits, if an employee decides to make sensible economies in his or her use of a health plan, the employer saves. Under the Heritage proposal, the employee pockets the savings. Thus Americans would have the incentive to "shop around" for the most economical health plan to meet their legal obligation and their other health care preferences.

This would reduce the rate of medical cost inflation by encouraging cost-consciousness and discouraging over-use of medical services. A family may choose a more restrictive Health Maintenance Organization (HMO), for instance, rather than a plan with an unlimited choice of physician and hospital, to save money for other things. Healthy families would have the incentive to buy coverage with a larger deductible than is typical today and pay directly for routine minor medical bills. Healthy families today have the incentive to press employers to provide first-dollar coverage and then to overuse the "free" benefits.