National Center for Policy Analysis

BRIEF ANALYSIS
No. 223
For immediate release:
Wednesday, February 19, 1997

A Health Policy Agenda for the 105th Congress

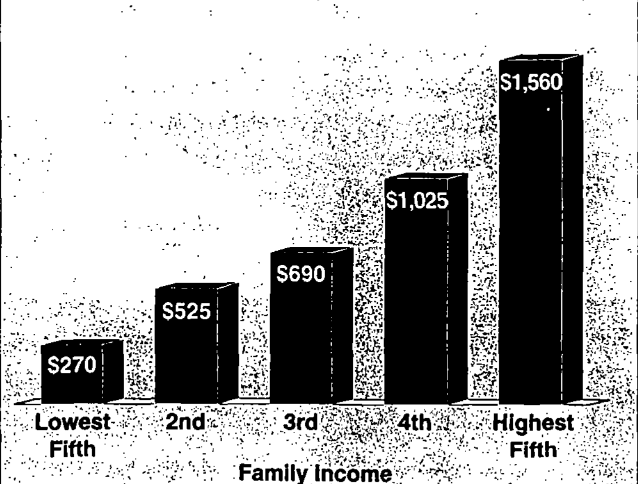
Most people believe there will be only incremental change in federal health policy over the next two years. President Clinton proposes to insure just 5 million of the approximately 40 million Americans who are uninsured at any one time, and his State of the Union message largely ignored other problems in health care policy. So far, the Republicans have no major health policy proposal.

But three major health care crises are developing: a funding crisis, an insurance crisis and a quality crisis. All three require fundamental changes in federal policy. And all three will become more severe if action is delayed.

Funding Crisis. Until recently, the American health care system paid for indigent care through a system of cost shifting. Some patients were overcharged so that others could be undercharged or given free care. Today, with 40 percent of hospital beds empty, the hospital marketplace is fiercely competitive. So is the market for physician services. Such competition is eliminating the ability to fund care for some by overcharging others.

Insurance Crisis. The number of Americans uninsured at any one time has steadily risen over the past decade and now totals more than 40 million people, nearly 10 million of whom are children. One reason for the rise is federal tax policy. Each year the federal government "spends" about $100 billion in subsidies for private health insurance by excluding employer-paid premiums from the employee's taxable income. We get what we subsidize. About 90 percent of all citizens with private health insurance get it through an employer, and those who do not have the opportunity to obtain tax-subsidized insurance often go without. Moreover, these tax breaks go mainly to middle- and upper-income families who least need the financial incentives. As Figure I shows, families in the top fifth of the income distribution get about six times as much relief as families in the bottom fifth.

FIGURE I
Average Tax Subsidy for Health Insurance[1]



[1] Subsidies include reduced Social Security (FICA) and income taxes.

Source: C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference on American Health Policy, Washington, DC, October 3-4, 1991.

Another reason for the problem is that a new federal law and a growing number of state laws require insurers to accept applicants regardless of their health status. These laws encourage people to go without health insurance while they are healthy by making it easy for them to obtain health insurance when they get sick.

Quality Crisis. Why are there so many stories about HMOs abusing sick people? One reason is that HMOs often compete in artificial markets, in which employers or government officials — not patients — determine who will provide care. Though many employees and increasing numbers of Medicare enrollees can choose among several HMO plans, even the process of choosing can impact the quality of care. The reason is that the HMO receives the same premium whatever the applicant's health status. Thus HMOs have an incentive to attract the healthy and avoid the sick, which they do in two ways. First, they overprovide care for the healthy by offering such amenities as health club subscriptions. Second, they underprovide care to the sick, encouraging them to take their business to some other health plan.

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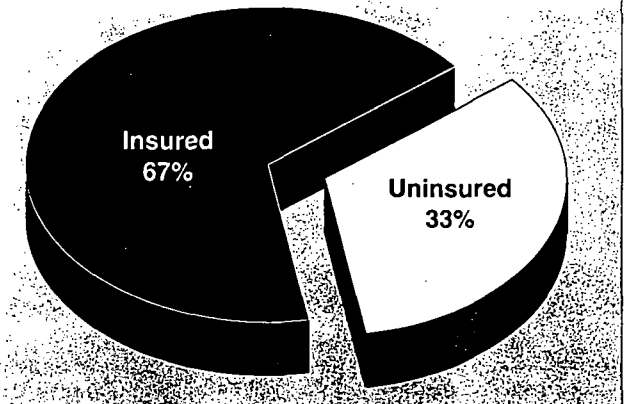
Solution: A $500 Tax Credit. We could go a long way toward solving these three crises by simply offering health insurance tax credits to people who are not insured by employers or by government. The tax credit would be refundable, so that people could file a tax return and receive a refund even if they owe no taxes. Since people who have employer-provided insurance receive an average tax subsidy of about $500 per year, a reasonable proposal would be to offer a $500 per person subsidy to every uninsured person who purchases insurance.

There are reasonable variations on this idea. Since health insurance for a child averages between $700 and $800 per year, a $500 subsidy is quite generous. The subsidy could se to $750 for an adult and be capped at $2,500 for a family of four. It also could rise as income falls, giving the greatest relief to those who need it most.

Fortunately, this program could be largely paid for by using funds already in the budget. Currently, the Earned Income Tax Credit (EITC) program spends about $25 billion in cash on payments to about 17.2 million low-income workers. The amount can reach $3,556 per family. As Figure II shows, most EITC families have health insurance, but about one-third do not. If payment of EITC were made conditional upon proof of insurance, families would have the choice of purchasing a private health insurance policy or having their EITC refund reduced by $500 per uninsured person. Similarly, the proposed $500 per child tax credit for middle-income families could be made conditional on proof of insurance.

FIGURE II

EITC Families*



* The Congressional Research Services uses the term "tax units," which consists of both families and individuals.

Source: Thomas Gabe, "Estimates of Number of Families Eligible for the Earned Income Tax Credit who are Without Health Care Coverage," Congressional Research Service, November 18, 1996.

Solution: A $500 Safety Net Payment. Under this proposal, everyone would either be insured or have $500 sent on their behalf to their state or local community as part of a safety net for indigent health care. Those without private insurance would be covered by a public system, and local communities would have a guaranteed source of funds for indigent care — one that would grow or shrink with changes in the numbers of uninsured. Communities also should have discretion over the use of such funds. For example, they might buy Medicaid for their uninsured or simply cover the medical bills the uninsured are unable to pay on their own.

Solution: Alternatives to HMOs. The $500 tax subsidy could be applied to the full range of insurance products in the market today, including fee-for-service health insurance and deposits to Medical Savings Accounts (MSAs). Thus people in such programs as Medicaid managed care would receive reasonable help from government if they wanted to choose a private alternative instead. This would encourage eventual competition between state Medicaid programs and private companies seeking to insure that population.

Conclusion. Insuring the nation's 40 million uninsured or at least providing them with safety net coverage is not as difficult as it may seem. And failure to do so will result in more serious problems in the future.

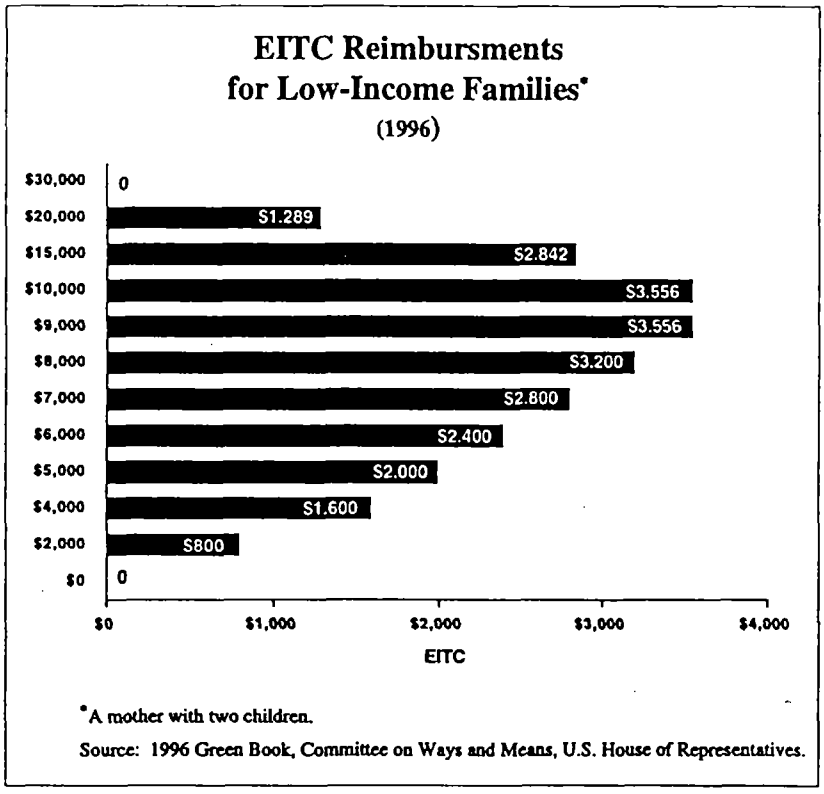
This Brief Analysis was prepared by John C. Goodman, president of the National Center for Policy Analysis.

BRIEF ANALYSIS
No. 218
For immediate release:
Tuesday, December 24, 1996

Insuring the Uninsured

The federal government currently subsidizes the employer-provided health insurance of middle- and upper-income workers by about $100 billion a year. By contrast, low-income workers often do not have employer-provided health coverage, and thus get neither the insurance nor the tax break. If they buy insurance on their own, they pay with aftertax dollars.

Congress is beginning to consider ways to increase access to health insurance. Health economists for years have recommended a system of tax credits for families that purchase their own policies. Yet while the money to subsidize upper-income workers' health insurance policies is available, the money to do so for low-income workers is not. Fortunately, an existing program — the Earned Income Tax Credit — could be altered to encourage low-income families to buy health insurance, and congressional proposals for a $500-per-child tax credit could be converted into a child health insurance tax credit for the middle class.



What Is the Earned Income Tax Credit program? Unlike an ordinary tax credit, the EITC provides a refund if the taxpayer does not owe any taxes. If a family's income tax obligation is less than the amount of the tax credit, the federal government pays them the difference. The EITC program currently spends about $25 billion to cover 18 million low-income workers. Of this amount, about 14 percent represents a refund of taxes recipients would have paid. The other 86 percent is a gift from the U.S. Treasury.

In 1996 an EITC family with two qualifying children could receive a subsidy of 34 percent (one child) or 40 percent (two or more children) of an income up to a maximum of $3,556 on earnings between $8,890 and $11,610. The credit is gradually phased out as earnings increase. The subsidy ends when adjusted gross income (AGI) reaches $25,078 for a recipient with one child, and $28,495 for those with two or more children.

An Earned Income Health Insurance Credit. The Earned Income Tax Credit could be converted into a health insurance credit. Under this proposal, families that receive health insurance through an employer or through Medicaid would receive their credit as usual. However, uninsured families would have to purchase health insurance in order to receive the full tax credit. (A variation on this proposal would require insurance only for children.) Families would have options under this plan.

They should be permitted to use their tax credit to cover all or part of the cost of a private health insurance policy. For example, the $3,556 maximum credit would be sufficient in many cases to cover the cost of a very basic traditional health insurance policy, a high-deductible plan with a Medical Savings Account or membership in a health maintenance organization (HMO). Money left over would belong to the family.

However, for other recipients the EITC money would be insufficient to cover the cost of a family health insurance policy. As the figure shows, those with earned incomes below $8,000 receive a smaller tax credit. Yet many of these individuals are enrolled in or eligible for

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state Medicaid programs. Those with higher incomes who also receive a smaller tax credit could supplement their credit with out-of-pocket funds.

Shoring Up the Safety Net. Unfortunately, some EITC recipients might decide to do nothing and continue relying on the emergency room for their primary care. This creates a financial strain on health care systems in local communities, as physicians and hospitals often must provide uncompensated care. Moreover, competition among providers makes it increasingly difficult to shift the costs of indigent care to other paying patients.

The health insurance tax credit helps to solve these related problems. For those who remain uninsured, choosing not to use their tax credit to purchase health insurance, the federal government could divert the credit to local public health authorities. When the uninsured received health care, they would be expected to pay for it, as they are today. If they could not, unclaimed tax credit money could help pay for their care. Thus those choosing to remain uninsured would be indirectly subsidizing part of the cost of their own health care.

Alternatively, a state or local community could permit families to transfer their EITC funds to programs providing medical services in their neighborhood. Since most states are shifting their low-income uninsured people into managed care programs, the practical effect of this "buy in" would be that the federal government would divert a family's EITC funds to the Medicaid managed care program in that family's community.

Benefits of EITC Reform. The original intent of the EITC was to supplement income and help to meet basic family needs year-round. Yet under the current system, people receive a single refund check in the spring and can quickly exhaust the funds. The program is also riddled with fraud and abuse.

The health insurance tax credit could help solve both problems. First, families would be able to pre-assign their credit to an insurer at any time and receive 12 months of continuous health coverage. Second, monitoring and oversight by the health insurer would reduce fraud and abuse.

In addition, changing the EITC program into a health insurance credit would add money to a system that is providing care anyway. Many states, operating under a waiver from the federal government, are using their Medicaid money to implement reforms that provide health insurance coverage for their uninsured populations. In other words, states are looking at ways to provide basic coverage for their uninsureds with current Medicaid dollars. Uninsured families who turned their EITC money over to the state Medicaid or local managed care program or community hospital would be adding money to a system already forced to provide them with care.

A Tax Credit for the Middle Class. Though permitting the EITC to become a health insurance tax credit would help 24 million workers with incomes below 200 percent of the poverty line to gain access to health insurance, it would do little for more than 11 million uninsured middle-income families (those with incomes 200-400 percent of the poverty line). One way to help them is to convert the $500-per-child tax credit, proposed in the Republicans' Contract With America and embraced by the Democrats, into a health insurance tax credit, or at least a child health insurance credit.

Implementation would be similar to the EITC proposal. Those who have health insurance would receive their credit. Families with uninsured children would have to use their credit for health insurance or receive nothing.

Using the children's tax credit would primarily benefit middle-class families, since those making under $20,000 currently pay little or no federal income taxes. Thus, families would have to have an income tax obligation of at least $500 to get the full value of the credit for one child.

Conclusion. Turning the EITC or child tax credit into a health insurance tax credit is one way to make health insurance accessible to low-income uninsured workers and families without creating a new federal program. The government already subsidizes health insurance for higher-income workers. Shouldn't low-income uninsured workers and their families also receive a subsidy?

This Brief Analysis was prepared by NCPA President John C. Goodman and Vice President of Domestic Policy Merrill Matthews Jr.

National Center for Policy Analysis

BRIEF ANALYSIS
No. 217
For immediate release:
Friday, December 20, 1996

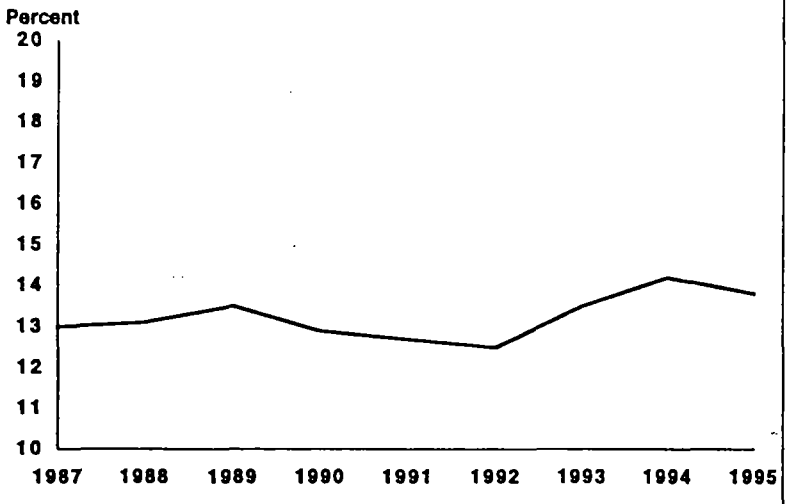
Is There an "Uninsured Children" Crisis?

In the next session of Congress, expect a major battle over health insurance for children. Proponents of government intervention want a Medicare program or a resurrection of the failed Clinton health care plan for children. And they are already starting their campaign.

Take, for example, John J. Sweeney, president of the AFL-CIO, who poured at least $35 million of union members' dues into political ads claiming that Republicans were trying to destroy Medicare. Speaking at a recent meeting of the American Public Health Association (APHA), Sweeney said, "If they [Republicans] don't come around, we'll use children's health the way we used Medicare, and that's a promise and a commitment."

Laying the Groundwork for Children's Health Insurance. In order to lay the groundwork for this battle, a number of liberal policy groups and special interests are commissioning studies to create a crisis mentality by conveying the notion that the number of uninsured children is rising and that they are currently unable to get adequate care, especially prenatal and preventive care and immunizations.

FIGURE I
Percentage of Uninsured Children
(Under Age 18)



Source: U.S. Census Bureau.

Bogus Claim #1: The number of uninsured children is growing rapidly. As Figure I shows, the percentage of uninsured children has, in fact, remained relatively stable over the past decade, with only a slight increase since President Clinton took office. However, the graph does not reveal the internal dynamics in children's health insurance coverage, and that's where the problem lies. In 1989, 63.2 percent of children received their health insurance through a parent's employer's plan, while 13.6 percent were covered under Medicaid. By 1993, only 57.6 percent had employer-based health insurance, and 19.9 percent were covered under Medicaid. Those without insurance increased only slightly, from 13.3 percent to 13.5 percent.

One reason for the decline in employer-based health insurance is rising costs. So what did the 104th Congress do last September, just before members went back to their districts to campaign? Passed, for the first time at the federal level, mandates — requiring insurers to pay for equal treatment of mental and physical health care problems and two-day hospital maternity stays — which will cause the cost of health insurance to go up.

State governments have already mandated well over 1,000 health insurance benefits for such services as chiropractic care, drug and alcohol abuse and marriage counseling. Studies in six states have found that mandated coverage accounts for between 7 and 21 percent of all insurance claims, depending on the state. As a result, the cost of health insurance has increased and employers have canceled policies — leaving more children uninsured. The 105th Congress will consider more mandates — even as it denounces the growing number of uninsured children.

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Bogus Claim #2: The only way to ensure that all mothers have prenatal care and that all children get vaccinations and primary care is by providing them with universal health insurance. While there are constant warnings that low-income children aren't getting enough care, the facts tell a different story.

According to the Health Care Financing Administration, almost 94 percent of all U.S. women get prenatal care in the first two trimesters. Only 6 percent wait until the third trimester or get no care at all. Those numbers could be improved, especially among African-American and Hispanic mothers, of whom only about 88 percent get prenatal care in the first two trimesters. Despite that fact, clearly there is no nationwide crisis.

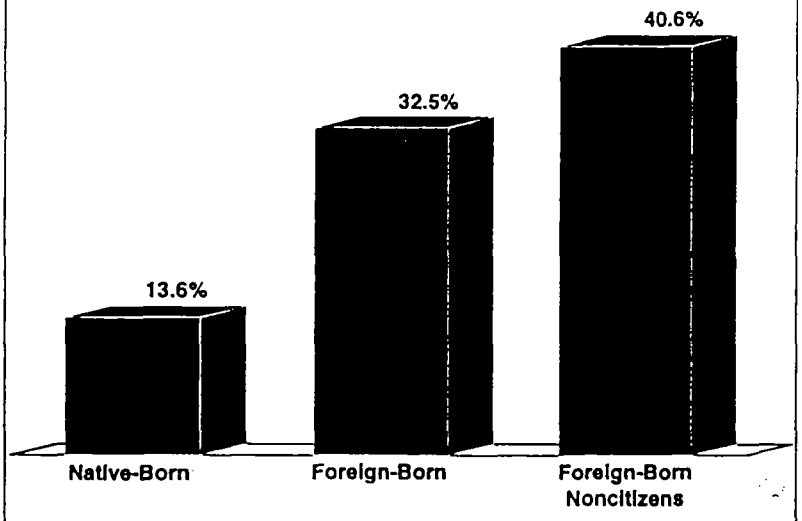
Nor is there a crisis with regard to immunizations. For example, in 1994 the *Journal of the American Medical Association* (JAMA) published a study of measles immunizations among 2-year-olds in Mississippi during a 1989-91 measles outbreak. Researchers found that immunization rates were "similar for white and black children in each district," and immunization rates were higher in rural than in urban areas. The rate ranged from 79 percent to 97 percent, according to geographical district, averaging 87 percent statewide. Virtually all school-age children were fully immunized because schools required immunization proof prior to enrollment. Again, not perfect, but far from a crisis.

Would more preventive care for children avert the development of expensive-to-treat conditions later on? The Office of Technology Assessment (OTA) has studied the cost-effectiveness of adding coverage for several preventive measures. It has found that only three kinds of preventive care save money: prenatal care for poor women, tests in newborns for certain congenital disorders and most childhood immunizations.

Where the Real Problem Lies. Rather than asking how we should socialize children's health care, policy makers should be asking how to reach those populations most at risk. For example, 25.6 percent of New Mexico's population is uninsured, compared to only 7.3 percent in Wisconsin. While part of that difference has to do with income and occupation, most of it has to do with demographic rather than economic differences. New Mexico has a disproportionate share of the immigrant population. According to the Census Bureau, 13.6 percent of the country's native-born population lacked health insurance in 1995, while 32.5 percent of the foreign-born were uninsured and 40.6 percent of foreign-born noncitizens lacked coverage. [See Figure II.]

FIGURE II

Uninsured By Citizenship Status



Source: U.S. Census Bureau.

Thus any nationwide health insurance program for children threatens to evolve into an entitlement program primarily benefiting legal and illegal immigrants — and to attract more immigrants even as states with large immigrant populations seek legislative remedies that reduce the financial burdens of immigration.

While the percentage of uninsured children has changed little, the demographics have changed significantly. And since the numbers vary from state to state, so should the solutions.

This Brief Analysis was prepared by Merrill Matthews Jr., NCPA vice president of domestic policy.