Rethinking Health Care Policy — The Case for Retargeting Tax Subsidies

by

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Its opponents may have defeated the Clinton administration's health care plan. But the problems it addressed have not gone away.[1] In many key respects, they have worsened. More Americans are without health insurance. Fiscal retrenchment threatens the public programs serving the old and the poor. And, while economies have been found in managed care, health care spending has continued to increase more rapidly than economic activity as a whole.

The rise of managed care itself has raised new concerns. It has transformed American medicine into a battleground of dispute between employer and employee, insurer and subscriber, doctor and patient – no surprise considering its incentives to economize on care, even when that means withholding care. Indeed, bonuses paid to physicians in capitated HMO plans are little more than thinly disguised kickbacks to do exactly that.

Economies from managed care are coming at a high price, depressing the revenues of hospitals and thus undermining the uncompensated-care cross subsidies that have acted as a safety net for the uninsured poor. Buying medical services from a "preferred provider organization" or PPO – a type of HMO structured to give subscribers special reduced rates – is, by its very nature, a way of avoiding having to pay for someone else's medical care.[2]

Hobbled by excess capacity and the underlying shift in the past decade from in-patient to out-patient care, hospitals have been ill-equipped to counter the newfound assertiveness of health insurance plans and their employer sponsors. They succeeded in developing profitable out-patient treatment when Medicare and Medicaid shifted in the early 1980s from retrospective payments (which are based on actual costs) to prospective payments (which are keyed to diagnoses upon

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[1] Henry J. Aaron, editor, "The Problem That Won't Go Away, Reforming U.S. Health Care Financing," Brookings Institution, 1996.
[2] Ibid., page 6.

admission). Hospitals also were in a position to cope with the revenue squeeze brought on by the new rules and with the resulting excess capacity, as they then had the market power to pass on unreimbursed costs to private payers.

Those options are now foreclosed. Indeed, with private payers driving an even harder bargain than Medicare and Medicaid, private hospitals are at risk of losing their role as agents of redistribution. Founded as eleemosynary institutions, they are now confused as to what they are and how they are to act.[3] The comforting, even self-justifying, axiom, "no margin, no mission," is perilously close to becoming "mission, no margin." Proliferating mergers may well help many hospitals defend themselves from the depression of fees, but they are unlikely to restore the redistributive role hospitals played in American life in the past.

Insurance market failure

Other major trends in American health care are also at least as troubling as they were a few years ago.

The cross subsidies from the healthy to the sick – they too a safety net – have all but disappeared in the individual and small-group insurance market. Those with a history of illness and in need of recourse to that market are at risk of being screened out – or offered unaffordable, if not pseudo, insurance made useless by the fine print. Techniques for underwriting – the process of dividing the market into risk categories – have become so aggressive that they are destroying the market for health insurance for those not covered in a large-group plan at work or by Medicare or Medicaid. Even large-group plans, which also have become aggressive in screening for pre-existing conditions, offer less protection that they once did.

The number of uninsured now exceeds 40 million. The breakdown of the individual and small-group insurance market has taken a toll. But

[3] Carl J. Schramm, commenting on a paper published in "American Health Policy, Critical Issues for Reform," Robert B. Helms, editor, The AEI Press, 1993.

so have several other forces. Increasingly, large companies have opted to out-source work that had been done in-house, shedding fringe benefits which can run quite high as a share of total compensation for low-paid workers. Increasingly also, employers who have continued to offer health insurance as part of a compensation package have passed on more of the cost to employees directly. The temptation to drop coverage and become a "free rider" on the system in the event of a major illness has risen accordingly, notably among the poorly paid whose compensation has dropped in absolute as well as relative terms. Strikingly, only 80% of Americans not covered under Medicare and Medicaid have health insurance, down more than 10 percentage points from the early 1980s. No different from many other aspects of American life, health care reflects the growing impoverishment of those at the bottom.

Medicare and Medicaid, to be sure, must figure prominently in the broader fiscal retrenchment if the deficit is to come down significantly. They account, after all, for 20% of the budget and for an even larger 28% of its growth in the past 10 years. But, just as in the trend to managed care, economies in the public programs are coming at a high price.

The partisan debate this past year over whether Medicaid should remain a federal entitlement has obscured the more important point that, under either the Clinton administration's or the Republican Congress' plan, Medicaid will finance even less of the health care of the poor than it does now. Even now, it finances care for only half of the population below the federal poverty line.

Public hospitals are in no position to cope with the pending cuts in Medicaid baseline budgets. Harder cases, but not the resources to treat them, have been shunted their way by revenue-squeezed private hospitals. What is more, public support has fallen because of the resulting perception of inefficiency and ineptitude. Never well funded, county and municipal hospitals have become even more financially strapped as States and localities, like employers, have retreated from earlier commitments.

Medicare – historically more secure than Medicaid because of the strength of its constituency – is also at risk as the post-World War II baby boom generation ages. Projections for the trust funds – and for the underlying imbalance between the beneficiary population and the taxpaying workforce – point to both cutbacks in real services and increases in tax rates. These will be all the larger the longer they are put off.

All of this bodes ill for the health care of the growing number of Americans that cannot afford to pay for their own care. And it bodes ill for the nation as a whole. It promises to leave health care all the more rationed by price – all the less a basic citizenship right as it is in just about every other advanced country of the world. At the very least, Americans will have more trouble than ever before squaring their own view of themselves as a caring people with such a form of rationing.

The financial stress hospitals face, moreover, will adversely affect the health care of even high-income Americans who can afford the best care. Teaching, research, and other public goods are also at risk. Quality can be expected to slip, just as public services have in the "high rent" districts of such cities as Washington, D.C. and Newark. Those neighborhoods have not been immune from the broader forces affecting the cities of which they are part.

Shift to a State focus

With the death of the Clinton administration's plan, efforts to expand access to health care have passed to State houses where reformers have made some progress – piecemeal, however, and at a disappointingly slow pace. Minnesota, Oregon, Washington, and Massachusetts all have backtracked on fiscal grounds from plans to cover the uninsured with "pay-or-play" mandates (which require employers to provide health insurance or pay into a public plan) and Medicaid "buy-ins" (which allow those not quite poor enough to be eligible for Medicaid to

qualify by paying part of the cost). ERISA, which circumscribes State power in the design of employee benefits, has also been a stumbling block. Tennessee has enrolled the uninsured in State-subsidized HMOs, although questions about quality at many of the participating organizations remain. Hawaii has had a pay-or-play plan in force since the 1970s, although it still does not cover dependents.

Progress at the State level has been slow for the two same fundamental reasons the Clinton plan foundered: the practical political difficulty of raising the revenue to cover the uninsured and the opposition of employers and of small but powerful constituencies with little to gain and much to lose from the cost control needed to make universal coverage work. Questions of "who pays" and "who stands to gain and who to lose" loom at the State as well as the federal level; they have proved no easier to answer there.

Legislation on such insurance issues as portability – along the lines of the Kennedy-Kassebaum bill approved in the Senate earlier this year – is almost certain to be passed in the next year or so. Portability, however, would provide access to health insurance to few Americans. Even now, under a provision of the 1985 budget reconciliation act (or COBRA), those who leave a job can take their health insurance with them, albeit at their own expense and only for 18 months. Portability, moreover, would not be costless. By facilitating access to health insurance for relatively high-risk subscribers, it would raise average premiums and thus would add to the problem of the uninsured on affordability grounds.

Portability would do little, if anything, to remedy this basic flaw of American health care. If that is to be addressed seriously, the nation must rethink how health care is financed. In particular, hard questions have to be raised about the reasonableness of subsidies coming now through the tax exclusion of employment-based health insurance – subsidies that now cost federal and State treasuries more than $80 billion annually.

Tax exclusion of employment-based health insurance causes those who can take advantage of it to make excessive claims on health care resources. And it is thus one of the main reasons why American medical care has become so costly, and, why, as a result, so many other Americans lack health insurance. The question of who pays becomes all the harder to answer politically when the bill is high. To the extent medical care is subsidized, it ought to be subsidized on the basis of real need. The nation would be greatly better off if that principle were to govern in health care policy (including in Medicare) as well as in every other aspect of public life.

This paper lays out the case for fundamental change in the way the nation finances health care. The first section, a diagnosis if you will, is a look at how the tax exclusion of employment-based health insurance has driven up health care costs and, as a result, has made it more difficult to get to universal coverage. The second, a prescription section, outlines the structure of an income-based, universal, tax-credit system. The third section lays out the challenge of forging a constituency around such a plan.

I. Dx: a financing scheme wrong from the start

Employment-based health insurance was an accident of history. It took root in the 1930s when hospitals – hard hit by the Great Depression – formed Blue Cross plans which secured their revenues by having people effectively prepay their hospital bills. But not until World War II, when Blue Cross came broadly into the workplace, did health insurance cover a large part of the population. Facing wartime wage controls, employers found health insurance – which was exempt from those controls – an efficient as well as perfectly legal way of recruiting skilled workers in unprecedentedly tight labor markets.

Further impetus to an employment-based system came in the early 1950s when the IRS ruled that health insurance paid by employers was not taxable to employees. The judgment was that it was hard to price the benefits an individual employee received in a group plan, and thus

hard to estimate the income on which tax would be due. Moreover, the amounts at issue were relatively small – too small, in any case, to raise broader fiscal issues. By the early 1960s, some 75% of the workforce was protected by employment-based health insurance, as compared with only 10% just before the war.

Two major groups were left out: the old and the unemployed, more generally the poor who when they got medical care relied on the charity of physicians as well as on cross subsidies coming through hospital billing. With Medicare and Medicaid designed to fill that gap in the mid-1960s, however, the nation was well on its way to fashioning a universal health care system. That system, the perspective was at the time, may have been different in design from the systems of other industrial countries where universal care was financed almost entirely by payroll or other taxes. But it was similar in function. The theory was that an ever larger share of the workforce would be protected by health insurance at the workplace, and that most others – important among them the over-65 population which, unlike today, was disproportionately poor in the 1960s – would have their medical care financed by the new public programs.

The working poor: the vast majority of the uninsured

The vision of a universal health care system based on employment and on entitlements for those without a job faded, however, as costs surged in the 1970s and 1980s. Rapidly rising costs prompted for-profit insurance companies to become adept at shunning potentially high-cost subscribers, and at selecting "good" (i.e., low) risks. Even Blue Cross was forced in many States by that competitive challenge to abandon the community rating principle on which it was founded.

The high cost of underwriting, in turn, pushed premiums in the individual and small-group insurance market to prohibitive levels, prompting many in that market to drop coverage, the tax exclusion notwithstanding in the case of small companies. Strikingly, administrative costs in the individual and small-group insurance market

today scale 40%. To be sure, the group-insurance model has remained for large companies (98% of employers with 100 or more employees offered health insurance in 1991, as compared with only 27% of employers with fewer than 10 employees).[4] But, through out-sourcing, even large companies have retreated from earlier commitments.

Rising medical costs, moreover, caused State governments (which have wide latitude in setting eligibility policies for Medicaid) to keep down the number of people who qualify for Medicaid on income grounds, and to restrict the services provided to those who do qualify. Many States have followed a strategy of not raising the maximum income levels for eligibility – a key reason why nationwide only about 50% of Americans falling below officially measured poverty levels are enrolled in Medicaid. Even so, with medical care costs rising rapidly over the years, Medicaid accounted in 1994 for 17% of State and local government budgets, up from 10% just ten years ago.

Not surprisingly, the uninsured population reflects these trends. It falls broadly into three groups:[5]

- *Those employed, which with their dependents account for about 75% of the total.* They tend to be low-wage (many at or just above the minimum wage) and employed at relatively small firms, particularly in the services industries. Turnover is high (one of the main reasons their employers cite for not offering health insurance). But the more fundamental problem is that even a bare-bones insurance package – priced at, say, $2,500 a year for a family – would be as much as one-quarter of the total compensation of a worker whose wage was at or just above the federal minimum. With health insurance especially costly in the small-group insurance market, the employer's choice all too often is to forgo it. Many employees would also forgo it (and take the equivalent cash income instead) if, in fact, they had a choice.

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[4] Cynthia B. Sullivan, Marianne Miller, and Claudia C. Johnson, "Employer-Sponsored Health Insurance in 1991," Health Insurance Association of America, 1992.

[5] Gail R. Wilensky, "Viable Strategies for Dealing with the Uninsured," Health Affairs, Spring 1987.

- *The medically uninsurable, which account for no more than 2% of the total.* They cannot obtain insurance because of preexisting conditions, even as employees of Fortune-500 companies. Many States have formed high-risk insurance pools, which are highly subsidized. But the appeal of the Kennedy-Kassebaum bill testifies to a problem not yet solved at the State level.

- *The nonworking indigent, which account for the remainder.* These are the long-term jobless and the chronically ill – many of them deinstitutionalized mentally ill, substance abusers, or homeless. They fit the Medicaid model – as it was conceived in the mid-1960s in any case. Their incomes are above the increasingly low cutoff levels set by their State governments, however.

The uninsured, it is true, have access to medical care. Much of it, however, is in the late stages of illness and in such high-cost settings as emergency rooms.[6] Limited access is reflected in unusually high in-hospital mortality rates and in the need for hospitalization for illnesses that usually are controlled, if not cured, by means of drugs and physician office visits when the patients are insured. The uninsured are twice as likely as the insured to be treated in a hospital setting for diabetes, for example.

Americans have been willing to tolerate the rationing of medical care by price on the belief that the rationing breaks down in the event of real need.[7] All too often, however, that is not the case. Typically the need is recognized tragically late – when, for example, the leg has to be amputated or the retina is ruined because of the effects of diabetes, rather than when the disease might have been easily controlled. Indeed, for rationing by price to endure, good myths about what constitutes real need are essential to maintain.

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[6] Laurie Kaye Abraham, "Mama Might Be Better Off Dead, The Failure of Health Policy in Urban America," The University of Chicago Press, 1993.

[7] Lawrence D. Brown, "The Medically Uninsured: Problems, Policies, and Politics," Journal of Health Politics, Policy and Law, Summer 1990.

Tax-free compensation in the guise of insurance

The high cost of American health care – and the associated problem of affordability of health insurance – can be viewed as the inevitable by-product of the method the nation stumbled on for financing health care. Moral hazard – the tendency of insurance to increase the risk that is insured against – is a threat to a well functioning insurance market under the best of circumstances.[8] But it is an especially large threat when premiums can be paid out of pretax income. The added problem with employment-based health insurance is that the consumer is hard to identify. The customary producer-consumer relationship is muddled by the quasi-consumer role of employers – that, too, the natural outcome of the tax exclusion.

Because of the exclusion, employees have more health insurance (and more income in the form of insurance) than they otherwise would. The insurance, if at all comprehensive, buys two services. One is protection against the financial consequences of a major unforeseen illness, a reasonable use of insurance to spread risk. The other is prepayment for routine and thoroughly predictable expenses that otherwise would have to be paid out of after-tax income, an unreasonable use of insurance redeemed only by the tax exclusion. The prepayment is not insurance in any real sense, but a form of tax-free compensation. The exclusion justifies the costs of using an insurance model; those costs would never be justified otherwise, as they are on top of the thoroughly predictable expenses that must be borne in any case.

The arena in which moral hazard holds sway is thus quite broad – extending even to such routine things as teeth-cleaning, treatment for head colds, and the bandaging of scraped knees: all high-probability but low-consequence events. Indeed, the exclusion pushed the health insurance industry in the direction of increasingly comprehensive benefits – and, then, as moral hazard would have confidently predicted, overuse of those benefits as if "free." This is hardly surprising. The effect of the exclusion on the choice between two insurance plans, one

[8] Mark A. Hall, "Reforming Private Health Insurance," The AEI Press, 1994.

comprehensive and the other less so, is to lower the cost difference between the two by the marginal tax rate – some 30% to 40% for most taxpayers if Social Security as well as income taxes are in the count.

Employers also benefit from the exclusion as it permits them to leverage their compensation dollar. The gains accrue disproportionately to large employers, however. Large employers are not saddled with the administrative costs of the small-group insurance market, and thus are in a much better position to leverage payroll costs.

Blunting market forces all the more

The problem with insurance from an economic or social point of view, it should be acknowledged, is its virtue from the individual's point of view. Insurance allows sick people to make choices about pursuing treatment with little, if any, regard for cost – no small gift at a time of trouble. But insurance – especially if it is excessive as a by-product of tax subsidies – reduces the incentive people otherwise would have to seek out efficient providers of care, and to monitor the care they are given. Market forces – which cannot work all that well in health care in any case – become weaker still.

The effect of tax-favored medical insurance is to spur new types of treatment that are better than the ones they replace, but also considerably more costly. As long as the insured patient does not confront out-of-pocket costs, the benefit-cost ratio of the new treatment has to fall to zero to make that treatment uneconomic from his perspective. Strikingly, the RAND Health Insurance Experiment, conducted throughout the country in the 1970s and 1980s, concluded that a $1,000 out-of-pocket deductible on a family plan reduced expenditures in the range of 25% to 30% relative to a plan without a deductible.[9]

[9] Joseph P. Newhouse and The Insurance Experiment Group, "Lessons from the RAND Health Insurance Experiment," Harvard University Press, 1993.

Moral hazard in employment-based health insurance and, as well, in Medicare and Medicaid spurred costs all the more in concert with retrospective payments. Reimbursement on the basis of actual costs tended to lead to many advances in technology that would yield some benefit but only at high cost. And it was an invitation to use those advances intensively. R&D was influenced by expected utilization, and the resulting technologies, in turn, expanded the demand for insurance. "If, for example," concluded one analysis of the interplay of health care R&D and reimbursement, "decision makers in the R&D sector believed that the development of a particular technology that was costly yet effective would cause government (and subsequently private payers) to expand insurance to cover it – as was done with kidney dialysis – there (was) ... an incentive to develop the product even though it was not covered under existing insurance."[10]

Top subsidies to top income

Apart from its effect on moral hazard, the exclusion violates canons of tax equity. The tax benefits rise with the employee's tax bracket, the comprehensiveness of his insurance plan, and the share paid by the employer. All three act against the principle of vertical tax equity to make the subsidy especially generous to high-income employees – the very people for whom insurance with high co-payments (a sure way to limit moral hazard) is particularly appropriate. Illustrative of the lack of vertical tax equity: The exclusion provides employees in the income range of $100,000 to $200,000 per year an average tax subsidy in the neighborhood of $2,000, as much as the average cost of health insurance for families with $10,000 in wages.[11] Horizontal tax equity, which calls for equal taxation of equal income, is also violated; 100% of employer-paid health insurance is exempt from taxation, whereas only 30% is exempt if the insurance is paid by a self-employed person on his own behalf.

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[10] Burton A. Weisbrod, "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," Journal of Economic Literature, June 1991.

[11] Congressional Budget Office, "The Tax Treatment of Employment-Based Health Insurance," March 1994.

Medical savings accounts suffer from the same deficiencies. And so do so-called flexcomp accounts which permit employees to make co-payments, and pay for noncovered health-related items like prescription eye glasses and cosmetic surgery, out of pretax income. Both tax wrinkles can be counted on to boost health care costs by broadening the arena over which moral hazard holds sway. They both also violate canons of tax equity, and, no different from any other "tax expenditure," require general tax rates to be higher than they otherwise would be.

Finally, American medical care has become high-cost (relative to the standards of the past as well as those of other industrial countries) because of the nation's reliance on medicine to deal with what, at bottom, are broader problems. All too often, medicine rather than social policy – by default rather than by design – has been the locus for dealing with urban violence, teen-age pregnancy, and other symptoms of the interplay of social disorder and poverty. And, all too often, medicine has done a bad – as well as costly – job of it. The nation ranks highest, for example, in infant mortality rates among developed countries (and compares unfavorably even with many developing countries). And, yet, standards in high-income States compare favorably with the rest of the industrial world's.[12]

Not a trade issue

The concern often voiced about the cost of American health care – from business, in particular – is that the nation's competitiveness suffers as a result. That is far from the real issue, however. Because it is in lieu of, not in addition to, wages and other benefits that otherwise would be paid, health insurance is but one aspect of labor cost. In any case, countries with whom the United States competes internationally typically have significantly higher fringe benefits.

[12] Leroy L. Schwartz, M.D., "The Medicalization of Social Problems: America's Special Health Care Dilemma," The AmHS Institute, 1995.

The real issue is alternative uses of resources – whether for education, other investment, remedy for the nation's social dysfunction, or any other purpose. A rise in health care expenditures faster than in expenditures as a whole "crowds out" those other expenditures – a truism, to be sure, but one rarely given enough emphasis in discussion as to why containing health care expenditures is important. Lower expenditures for health care would not help the United States compete more effectively in international trade; it would, however, make for "better" use of national resources.

Too little, side by side with too much

Cost control, in particular, would provide scope for dealing with the problem of the uninsured. At the very least, it would ease the resource constraint that has been at the heart of the failure – by several of its predecessors as well as by the Clinton administration – to achieve universal coverage.

It is not that the 14% of the nation's GDP dedicated to health care is already "too high" in some absolute sense.[13] That level would be hard to quarrel with if it were the outcome of after-tax spending decisions. The country, instead, has both too little and too much health care – the natural outcome of spotty public programs for the poor and, at the same time, widespread use of tax-free financing for most of the rest of the population. Because of subsidization through the tax system, the price of health insurance (and thus of the underlying medical care) has become inflated, causing it to become unaffordable for all too many people and, yet, effectively priced too low for most others. The institutional structure that has priced so many out of the health insurance market has made it difficult, if not prohibitive, to care for them at public expense.[14]

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[13] "Data View: National Health Expenditures, 1994," Health Care Financing Review, Spring 1996.
[14] Clark C. Havighurst, "Health Care Choices; Private Contracts as Instruments of Health Reform," The AEI Press, 1995, pages 18-19.

Legacies of the past

While promising for cost control in the long run, managed care will be hard pressed to offset the forces that have caused American medical care costs to soar and that have, in the process, blocked universal coverage. It will be difficult, for example, to alter the practice patterns of generations of comprehensive insurance coverage made logical only by the tax exclusion, retrospective reimbursement, and fee-for-service medicine.[15] Every incentive under that structure was to reduce risk in the pursuit of a diagnosis and a course of treatment – and, drawing on the virtue of insurance from the perspective of the individual, to do so with little regard to cost.

The ability of HMOs to shadow-price traditional indemnity insurance in many markets also suggests slow progress on cost-control. If that is any indication of the competitive forces at work, it will be a long time before real savings, rather than mere redistribution of the health care dollar between practitioner and business owner, are effected. Whether the savings of the HMO model derived from experience largely with the youngest and healthiest groups of society can be extrapolated to the population at large also remains to be seen.

In the meantime, the clash between what managed care plans (and their employer sponsors) are willing to underwrite and the care the public expects hospitals and doctors to provide on the basis of custom raises new questions about the reasonableness of employment-based health insurance. Historically, the pattern has been for employers to choose the kind of medical plan their employees themselves would have opted for – no surprise considering how health insurance has been used to attract and hold skilled employees. Now, in contrast, as part of a broader business strategy to control health care costs, many employees have been virtually compelled to join HMOs. The resulting loss of freedom undermines whatever logic there might have been for

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[15] George Bernard Shaw was among fee-for-service's sternest critics: "That any sane nation," he wrote in Preface on Doctors, "having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg is enough to make one despair of political humanity." Quoted from Complete Plays with Prefaces, Dodd, Mead and Company, 1963, page 1.

employment-based health insurance. And so does the fact that even Fortune-500 companies – ATT itself – have moved away from the concept of a career job.

II. Rx: use the tax exclusion to fund universal care

Both of these questions come on top of long-standing concern on the part of economists that the tax exclusion is central to the interrelated problems of the costliness of care and lack of access to care for a large minority of Americans. All along, tax-subsidized employment-based health care has made American medical care inordinately expensive and, in the process, exclusionary. And now it is also dated, linked to a model of the labor market that no longer reflects reality. These are fundamental flaws, not remedied by portability and other essentially small changes.

A reasonable alternative – one that holds out promise of controlling costs as well as provides protection to the uninsured – is to require people to have health insurance and to subsidize it as necessary. They would obtain insurance as individuals rather than as employees. And they would pay for it out of after-tax income, helped if needed by a tax credit which could be financed by ending the tax exclusion.

Taxation of employment-based health insurance would not be all that path-breaking. For the past several years, the imputed value of life-insurance benefits in excess of $50,000, paid as part of an employee's overall compensation, have been subject to tax. And the original justification for the exclusion – that the income is hard to identify in group health insurance – is no longer valid. COBRA plans can be valued; indeed, they must be for the former employee to get a fair bill. And so can plans that offer employees a chance to choose among an HMO and a low- or high-deductible indemnity plan.

An individual mandate and replacement of the exclusion with a credit scaled to income are the key features of a plan put forth several years ago by Mark Pauly and his associates – a plan designed to achieve

universal coverage and, yet, build in incentives to contain costs.[16] According to that plan, families with income at or near poverty levels would qualify for a credit of 100% (to finance a basic, although comprehensive, health plan); the credit would be reduced progressively as income rises, reaching zero at, say, four or five times poverty levels.

A requirement that people carry health insurance may seem burdensome. It is no more so, however, than the requirement that car owners carry liability insurance because an uninsured driver represents an unfair potential cost to everyone else on the road. A mandate is needed to prevent people from self-insuring and effectively passing on the cost of their medical care, when it become financially ruinous to them personally, to society at large. And it is not all that onerous if it is accompanied, as needed, by the financial resources to pay for it. A mandate, moreover, is less of a constraint on freedom than it would have been in an earlier age when employees had greater choice of medical care than they have now in an age of the HMO.

Revenue neutrality

A health care reform plan that would gear tax subsidies to need – and, at the same time, be revenue-neutral – would have to weigh a number of trade-offs. Most important among them are (a) the size of the tax credit that would apply at the lowest income levels (and, jointly with that, the scope of the medical services to be covered under a basic plan) and (b) how much subsidy is appropriate at other income levels. It is clear, however, that ending the tax exclusion (especially if lost State tax proceeds were added in) would yield revenues adequate to

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[16] Mark V. Pauly, Patricia Danzon, Paul J. Feldstein, and John Hoff, "Responsible National Health Insurance," American Enterprise Institute, 1993. The Heritage Foundation has put forth a similar plan ("A policy maker's guide to the health care crisis," Stuart M. Butler, 1992). It differs most importantly from the Pauly plan in having the tax credit open-ended, keyed to the actual health care spending of an individual or a family, instead of capped at a specific dollar figure. The Heritage plan was incorporated in the Nickle-Stearns bill considered in the 1993 Congressional session, and it formed the basis for the health care proposals put forth by President Bush in the 1992 presidential campaign. C. Eugene Steuerle of The Urban Institute is yet another leading advocate for replacing the tax exclusion with a credit (see "The Search for Adaptable Health Policy through Finance-based Reform," published in Helms, op. cit., pages 334-361).

provide the needy uninsured with comprehensive, even if basic, coverage – plus offer some subsidization well into the middle-income range.

There would be ample scope for both in the $74 billion of forgone federal income and payroll taxes the exclusion represented in 1994, plus the $5 billion of revenue lost that year to State treasuries. The budgetary resources to fund a tax credit could also count on the $11 billion per year Medicaid disburses to hospitals in "disproportionate share funds" to assist them in the payment of uncompensated care – plus matching funds and other similar support from State treasuries.[17] With universal coverage, such assistance would no longer be necessary.

Fashioning the basic plan

However complex the trade-offs, the principles of retargeting the subsidies – and, as well, the mechanics of it – are straightforward.

As with any redistribution of income, the political process would have to find a way to balance the interests of the beneficiaries against those of the payers (indeed, every public service as well as every benefit program must strike such a balance). The credit would have to be high enough to provide genuine coverage (the diabetes would have to be treated at onset) – and, yet, not so high as to underwrite the kind of medical care that most unsubsidized consumers would forgo for themselves, especially if they had to pay for it with after-tax dollars.

Extending health insurance to all would not mean provision of all the health care that is technically feasible to provide. But it would mean that all would be covered with a minimum level of adequate, if basic, care. No one, however, would be constrained from buying insurance that provided a deeper set of services, although all such insurance would have to be paid for with after-tax dollars.

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[17] Telephone conversation with John Sheils, The Lewin Group, June 12, 1996.

One option for the basic plan would be to go with any relatively low-cost plan that had already captured a sizable market share. The dollar amount of the full credit would vary, however, with the age of the subscriber, family size, region of the country, and perhaps a few other broad categories – only a few, however, in order to push the insurance market away from risk-rating.

Another approach would be to draw on the experience of Oregon, Washington, and other States that have given serious thought to the kind of services government ought to make available when State funds are used in paying medical bills. While fiscal squeeze in those States has blocked efforts at universal coverage, the groundwork for the nature and scope of public support for medical care has been carefully prepared. Similarly, existing Medicaid coverage could be the basis for the federal design of a basic plan.

The federal government's role would be to ensure that plans funded by the tax credit had met minimal standards of protection for subscribers. And it would also be to channel high-risk subscribers to insurance pools, and to subsidize the higher cost as necessary. Significantly, a standards role for the federal government would preempt State laws mandating inclusion of specific medical services in insurance plans – laws that have been important among the forces raising health care costs and that also have worked to the disadvantage of employees of small firms. As a practical matter, those firms cannot avoid State mandates (and also State taxes on health insurance) by self-insuring under ERISA.

Taxpayers would qualify for a credit against their income tax for all or part of the cost of health insurance that either their employers had paid on their behalf or they had paid directly, ending at a stroke the horizontal as well as the vertical inequity in the tax exclusion. Nontaxpayers (most of them presumably in the lowest income brackets) would have designated State or local government agencies pay the credit directly to the insurance carriers.

The object of the credit would be to fund basic, but comprehensive, health care that families could not fund for themselves without risk of catastrophic financial loss. This means that no deductibles or other co-payments would be required at relatively low income levels; the credit in that case would be adequate to cover the full cost of the basic plan. As income rises, the credit would fall below the cost of the plan; the insured would pay the rest of whatever health insurance they obtain, plus any deductibles and other co-payments, out of after-tax income. As income further rises, the credit would fall to zero; all of the cost of health insurance, plus co-payments, would come from after-tax income.

The Congressional Budget Office has designed an illustrative tax credit that would replace the 1994 tax exclusion in a revenue-neutral way. In its calculations, the credit would equal 100% of premiums of $1,775 for single returns, $4,425 for joint returns, and $3,750 for head-of-household returns for those with incomes below the threshold for filing income taxes. It would be phased out for incomes between one and three times the threshold: $6,250 to $18,750 for single returns, $16,150 to $48,450 for joint returns, and $12,950 to $38,850 for head-of-household returns.[18] A family with adjusted gross income of, for example, $25,000 in 1994 would qualify for a 73% credit on premiums up to $4,425.[19]

Providing proof of coverage

Not only would the amount of the credit vary with income, so also would the required health insurance. All that would be required is that a family have enough insurance to meet unforeseen medical bills without stretching its financial resources unduly – in effect, have "catastrophic" coverage. Alternatively, people at all income levels

[18] One criticism of a credit that starts high and ends low is that it involves high progressive taxation over the income range of the phase-out. That is true enough. But that is a problem of every means-tested program. It is in the very nature of subsidies pinpointed to need.
[19] Congressional Budget Office, op. cit., page 44.

(including those well-heeled enough to self-insure) would be required to purchase the basic package.[20]

Evidence of insurance coverage would have to be supplied to the IRS, either by taxpayers themselves (employees could use a W-4 form) or by the State or local agencies acting on behalf of nontaxpayers. Taxpayers failing to provide such evidence would be enrolled in a fallback insurance plan, to be funded by surtaxes levied on those taxpayers. The federal government would select fallback plans by competitive bidding in each geographic market area – a way not only of enforcing universal coverage but also of goading the health insurance market back to the principle of community rating.

Getting to real insurance

Ending the tax exclusion and replacing it with, in effect, an income-scaled voucher would alter the health insurance market in a variety of ways. In so doing, it would have major implications for health care delivery.

Without the exclusion to make it reasonable to use insurance premiums to pay routine and predictable expenses, and with the tax credit capped at the cost of the basic plan, Americans would seek out less expensive insurance. The change would push the health insurance market toward catastrophic coverage, featured by high deductibles and other co-payments, thus saving on the claims processing and other administrative costs now associated with the use of insurance for the payment of routine and predictable expenses. It thus would reduce moral hazard and, in turn, the pressure on costs ensuing from the illusion that medical care is somehow free – or, at the very least, not to be valued at its full cost. Individual, high co-payment, policies would

[20] The principle that all carry health insurance designed to rule out catastrophic financial loss would theoretically exempt a Rockefeller or others of virtually unlimited resources. It would not be necessary for them to be insured to prevent them from becoming free riders on the system. It presumably would be necessary as a matter of practical politics, however, just as it is in the case of mandatory automobile insurance.

offer a good alternative to an HMO to employees that now have little, if any, choice.

With such a change, health insurance would come to be viewed not as an entitlement linked to a job, but as real insurance – protection against chance but potentially devastating financial consequences. It would be, in effect, "last-dollar," not "first-dollar," coverage. The plan, in short, would go far beyond budgetary neutrality to promise real economies in the use of resources.

The ad hoc subsidies now flowing through hospital billing – but ultimately paid by society at large – would be made explicit and transparent. And there would be better balance between routine and emergency care. Just as with any other universal plan, the care now given to the uninsured who cannot afford to pay for it would be provided earlier and in much less costly settings.

A requirement that all be insured would remedy the problem of adverse selection, which along with moral hazard is endemic to insurance. Because of adverse selection, low risks tend to self-insure, thereby pushing up costs for those left in the insurance pool (high risks tend to over-insure, with similar effect on costs). With a mandate, however, each insurer would "expect to get a random slice of all risks, and there is no need to charge a premium higher than the average expected for a given risk class," write Pauly and his associates in support of their plan.[21]

A mandate thus would push the health insurance market in the direction of renewable, long-term, contracts – the essence of community rating. When insurance is voluntary, such a model is unstable. But it is not when insurance is universal. A mandate, of course, would not make health insurance affordable for the working poor (it would have to be attached to a tax credit or other subsidies). But it would undo the breakdown of the individual and small-group insurance market that has prevented others from obtaining to affordable coverage. Indeed, universal coverage may well be essential to a well functioning health

[21] Pauly et alia, op. cit., page 31.

insurance market. Without it, risk-rating drives out the sick, making coverage prohibitively expensive for them to maintain – thus defeating the whole purpose of insurance. And, without universal coverage, community rating drives out the healthy, as it raise average prices.

Toward a more efficient labor market

Severing the link between health insurance and a job would go far beyond portability in breaking job-lock. Today's financing of health care has produced a form of insurance that is basically a term, rather than a renewable, product. It yields security only as long as the job itself lasts. It also discriminates against the young, the unskilled, and others with relatively high job turnover.

The overall efficiency of the labor market would also benefit if large employers were to lose the advantage they now have vis-à-vis small employers in leveraging compensation costs. Efficiency also would be served if the tax rates of the salaried and the self-employed were on the same footing; if the discrimination that keeps people out of a job because their potential employer's health care costs might soar were ended; and if decisions to retire before age 65 when Medicare becomes applicable were not affected by health insurance considerations.

A key question is whether employers would continue to play a major role in health insurance if they no longer were able to leverage labor costs by means of the tax exclusion. They would have less incentive to act as mere sponsors of insurance plans: evaluating plans on behalf of their employees, collecting premiums, and otherwise overseeing the functioning of the plans. Even so, incentives would remain. Employers, especially those of any size, are uniquely qualified to process information about insurance contracts on behalf of their employees. Group health insurance, moreover, even if taxable to the employee, is apt to continue to be significantly cheaper than individual insurance. And employers are naturals at pooling risk, and thus at fostering community rating in the insurance market – perhaps the only real virtue of an employment-based system. Employers as well as

employees would benefit on all three counts from continued employer sponsorship of health plans (just as they both do in the case of taxable life insurance).

Alternatively, unions, trade and professional associations, and other nonprofit organizations – or government itself – would have to assume an even larger sponsorship role. Or new sponsors would have to emerge: churches, civic organizations, and other community groups which can naturally pool risk.[22] Indeed, such sponsors would have to undertake the role corporate benefits officers now play if, in fact, business were to retreat from sponsorship of health insurance with the end of the tax exclusion.

Cost savings: two views

How health care expenditures would be affected by replacing the tax exclusion with a credit is hard to prejudge. Even so, the RAND experiment suggests that the resulting trend to higher co-payments would give rise to significant economies. Those could well offset much, if not all, of the additional cost of going to a universal system, especially since universality itself would yield economies in the early detection and treatment of disease. One study of the effect of ending the exclusion found savings as high as one-third of the medical care spending that is driven by employment-based insurance.[23] While other such studies have been less optimistic, they nevertheless have found savings in the range of 10% to 20% for private sector health care expenditures, about half of that range for the system as a whole.[24] The savings would be even larger if viewed in the broader context of a more efficient labor market.

Increased oversight by consumers of the costs of their medical care, other claims, would do little to curb costs because these are so

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[22] Conversation with Robert E. Moffit of The Heritage Foundation, February 23, 1996.
[23] Charles E. Phelps, "The Interrelated Markets for Medical Care and Health Insurance," draft, February 17, 1996.
[24] These are cited in Sherry Glied, "Revising the Tax Treatment of Employer-provided Health Insurance," The AEI Press, 1994, pages 15 and 34.

dominated by life-and-death considerations. The judgment is that high co-payments would have minimal effect since almost one-third of all of the nation's health care spending goes to only 1% of the population in a given year; almost three-quarters of the spending, to but 10%.

These percentages underscore the extent to which U.S. health care devotes resources to the difficult cases, often at life's end. But that is hardly a justification for perpetuating a tax system whose incentives to overuse of medical care for a large majority of the population have been wrong from the start. A better tax system will change the benefit-cost ratios for a wide range of medical interventions. And it will avoid the waste of using insurance claims to pay for routine care. But it cannot be expected to offer guidance on the volume of resources to be dedicated to a grossly underweight newborn or to a 70-year old in dire need of a new heart or kidney. No matter how sound the tax treatment of medical care costs, such ethical questions – which go to the community's claim on scarce resources as well as the individual's – will remain. Indeed, those questions will become even harder to answer in coming years as health care accounts for an even larger share of GDP. Even taking into account the slowing in the growth of health care spending in the past several years, health care is projected to consume 18% of GDP by the year 2005 according to official projections.[25] And the potential is for even steeper rise thereafter because of the aging of the postwar baby boom.

Alternative approaches

Universality could be achieved through a variety of other means. All of them, however, are flawed in one way or another.

Pay-or-play, the essential feature of the Clinton administration's plan, is regressive in its implicit payroll taxation of those at the bottom of the income distribution. Since health insurance is, in fact, paid by employees and not by employers, pay-or-play effectively compels low-

[25] Sally T. Burner and Daniel R. Waldo, "National Health Expenditure Projections, 1994-2005," Health Care Financing Review, Summer 1995.

wage employees to dedicate an inordinately large share of their income to health care. And it perpetuates the fiction that it is the employer and not the employee who pays the bill.

Pay-or-play also invites employers to game the system – encouraging them to switch, for example, from full- to part-time workers who as a practical matter would not be covered. The incentive also is to "pay," that is, to call on the subsidies to small firms that also as a practical matter have been a feature of the public plans employers can choose to pay into. Such an approach is wide of the mark in viewing the size of firm, rather than the income of the employee, as the key problem of the uninsured. Pay-or-play, moreover, further institutionalizes employment-based health insurance in a labor market increasingly at odds with the permanence needed to make such a system work well for much of the workforce. It would have to be supplemented with cumbersome programs to extend health insurance to non-employees and part-time workers.

All-payer systems along the lines of the Canadian model are said to be administratively simple, and thus channel more of the health care dollar to actual patient care. Much of the cost of public monopoly systems is hidden, however. Controlling moral hazard shows up in the cost of claims administration in the U.S. system, but not in the Canadian where it is buried in the cost of budgeting.

Budget constraints at the level of the local Canadian hospital have frequently spelled inordinately long delays for surgical procedures. And wraps on physician fees have meant several short visits for patients with illnesses more efficiently treated at one go. "The rough empirical evidence," writes Patricia Danzon, "tends to confirm that overhead costs in Canada, adjusted to include some of the most significant hidden costs, are indeed higher than under private insurance in the United States. Although there may be waste in U.S. private insurance markets at present, this waste is attributable primarily to tax and regulatory factors (such as the tax exclusion) and is not intrinsic to private health insurance."[26]

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[26] Patricia M. Danzon, "The Hidden Costs of Budget-constrained Health Insurance," published in Helms,

Even on the premise that the Canadian model had the edge on overhead, it would be hard to replicate in the United States (especially now that fee-for-service medicine, which is essential to the model, is in decline). Shifting to the public sector the 8% of GDP that private health care represents out of the total of 14% is the biggest problem of all in a country wary of government – the key reason why the Clinton administration, however much it might have been tempted by the Canadian model, rejected it a priori.

Medicaid buy-ins would resurrect Medicaid's original design for the inclusion of all low-income households in medical care plans not unlike the general population's. They would be scaled to income, which would limit their budgetary consequences. Those consequences nevertheless would be sizable, given the low incomes of most of the uninsured. Buy-ins, moreover, would extend a program that increasingly is identified with heavy-handed regulation, red tape, and stigmatizing of the poor. And they would leave employment-based health insurance, with its growing insecurity for much of the work force, intact.

Adding in the public programs

These considerations point to extending health insurance tax credits to the Medicaid population, rather than to enlarging the program itself. The added advantage of that approach is that it would eliminate the disincentive Medicaid recipients now have to find a job lest they lose their health care – the so-called notch problem. That will have to be addressed if there is to be a serious national effort to move people off welfare and into work. A health insurance tax credit for the working poor (they would be the main beneficiaries) is functionally the same as the earned income tax credit, although it would be earmarked for an expenditure of broad social as well as individual benefit.

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op. cit., page 280.

Tax credits would not, it is true, meet the health care needs of the deinstitutionalized mentally ill and other "walking wounded" who make up a sizable minority of the uninsured. There would remain a need to develop and fund walk-in clinics and otherwise devote resources to "poverty medicine."[27] The United States would do well to take a lesson from Japan where public health facilities are widely used for pre-natal care, immunizations, and a few other critical interventions. Poverty medicine can do only so much, however. The issues are far upstream of even the most apt health care institutions. They will have to be addressed in a much broader framework.

Medicare also could be brought into a credit arrangement. And it probably ought to be on the principle that subsidies for health care should be based on need for the over-65 population no less than for the population at large. A heavily subsidized health care plan that is blind to income for all over age 65 may have made sense in the mid-1960s. Health care was 6% of GDP; the income of the elderly was significantly below that of the population at large; and life expectancies were distinctly lower than they are today. But the approach that may have been reasonable 30 years ago has never been seriously re-examined in the light of vastly changed circumstances. Subsidization, in fact, has become even deeper over the years as beneficiaries (even those at high income) have come to pay an even smaller share of overall Medicare costs.

It would be unreasonable – indeed unfair – to cut back on the tax subsidies to health care provided through employment for those at relatively high income, and yet leave alone the subsidies provided through Medicare for a similarly well-heeled population. Lamentably, however, the Medicare debate has been focused on fiscal aggregates, rather than on the level of subsidy that beneficiaries ought to receive. In practice, that approach means top-down budgeting and continued squeezing of the incomes of hospitals and physicians – at the risk of loss of quality which would harm not only Medicare beneficiaries but the population at large. Lack of focus on income-appropriate levels of

[27] David Hilfiker, M.D., "Not All of Us Are Saints, A Doctor's Journey with the Poor," Hill and Wang, 1994.

subsidy also means a rise in premiums for all beneficiaries, including those at low income, which would be highly regressive.

The underlying premise of the debate has been that "cuts" from baseline budgets should affect beneficiaries evenly rather than be targeted to groups less in need of subsidization than others. Too little consideration has been given, for example, to linking premiums to ability to pay – something that would offset some of the fiscal squeeze in the offing. For example, Part B premiums, which cover physician bills, could be raised substantially for relatively high-income beneficiaries without even reaching the 50% share of the cost of Part B those premiums were supposed to finance when Medicare was established first.

Broader reform might well include integration of Part A (which covers hospitalization expenses and is fully funded by payroll taxes) and Part B (which today is 75% funded by general revenue, 25% by beneficiary premiums). Indeed, there is little, if any, reason to distinguish between Parts A and B, or to finance them from different sources. The rationale all along has been that Part B is voluntary. But, with participation in Part B effectively 100% because the program is so highly subsidized, the distinction is meaningless. To the extent there is a public interest in subsidizing medical care for the elderly, that interest extends across the whole range of covered medical services.[28]

Integrating the two Medicare programs – especially the financing of them – would provide an opportunity to take a step in the direction of the principle of ability to pay, paralleling the design of tax credit. And it also would be occasion to move to a voucher or premium-support system, that too paralleling the design of the tax credit. The premiums of a combined program could be keyed to the incomes of beneficiaries. And, depending again on income level, vouchers could be considered partly or wholly taxable income.

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[28] Henry J. Aaron and Robert D. Reischauer, " The Medicare Reform Debate: What Is the Next Step?" The Brooking Review, Winter 1995.

Integrating the public programs into a tax credit plan – or at least putting them on comparable footing on the principle of ability to pay – would also give the nation an effective mechanism for governing the volume of subsidies to health care. That, in turn, would act as a needed brake on the share of GDP dedicated to health care on the eve of the aging of the postwar baby boom.

III. On to the next round

Prospects for significant reform of American institutions are rarely especially bright. But there are times when real change seems possible, as it did for health care as the Clinton administration took office. It then seemed possible to marshal political support for universal coverage if that could be linked to "middle-class" concern about the growing insecurity of employment-based health insurance.

The anxieties and uncertainties the plan itself gave rise to no doubt contributed to its rejection in the Congress. The inclusionary strategy – with its provision, for example, for long-term care, drug costs, and early-retiree insurance – drove up the plan's potential costs. And that, in turn, led to concern that promised savings in health care delivery would not materialize at all early enough to pay for such a strategy. Harry and Louise (acting on behalf of traditional indemnity insurers who were fearful of the plan's emphasis on managed care and community rating) also did damage. The media, unable to make sense out of inevitably complex issues, failed to provide much of a foil to the myths and distortions the image makers succeeded in getting across.

Ultimately, however, it was the Clinton administration's Republican adversaries that brought down the plan. They were adept at labeling pay-or-play as implicit taxation, and thus at exploiting the mistrust of government. Few constituencies were ready to do battle for the plan, and had at the same time ample resources and the voice to do so.

Health care reform of any size and scope is thus off the policy agenda for now. Understandably, Democrats are reluctant to embrace

anything beyond such minor changes as portability. Republicans are also fearful, however – particularly of making of Medicare a "third rail" political issue of the kind Social Security retirement has become over the years. They must, however, push for substantial reductions in Medicare as well as in Medicaid baseline budgets if their embrace of deficit reduction at large is to be at all credible.

All the same, health care reform is apt to resurface as a major national issue in the next few years. The growing ranks of the uninsured, the cost consequences of misdirected subsidies, the breakdown of the individual and small-group insurance market: None of these will have gone away. Nor will the clash in the workplace arising out of growing restriction on the kind of insurance plan employees may choose.

Appealing beyond the narrow interest

The next time round, replacing the tax exclusion with a tax credit may well get a serious hearing. It addresses all of these issues, and promises at the same time to help control health care costs through economical choice of insurance plan.

Building a constituency for it will not be easy. The idea has not been accepted among those on the Right who typically have viewed it as a tax increase – one that, besides, would make the federal tax system at least slightly more progressive than it is now. Those on the Left typically have been opposed on grounds that health care benefits were negotiated in lieu of wages. It would be unfair, their contention is, to lessen the value of those benefits by making them taxable.

A constituency can be fashioned, however. The point to be stressed most is that individual-based health insurance cuts the increasingly tenuous link between health care and employment. It instead ties the health care security of most middle-income Americans to the welfare of the uninsured poor, and thus makes universal care not just an act of benevolence but one of self-interest as well. Moreover, those that would benefit from a credit, net of a lost tax exclusion, would extend

well into the middle-income groups, judging by the calculations of both CBO and Pauly and his associates. Even many high-income people, who would be net losers looking narrowly at their tax returns, would benefit by seeking cost-efficient health insurance. They would be able to pocket 100% of the difference in price between one plan and another, rather than 100% minus their marginal tax rates. And, like everyone else, they would profit from the control of health care costs apt to come about from the purchase of cost-efficient insurance.

The benefits for relatively high-income Americans would have to be seen – and sold politically – in a broader context, however. They would have to be found in the virtues of a universal system: an end to cost-shifting – a hidden tax but a tax all the same – relief from the squeeze on hospital revenue that threatens the quality of health care for even those of unlimited means, and a clear conscience that people in need are cared for, in more than myth. The appeal would have to be to the axiom of Adam Smith that people are prosperous in a prosperous society.

Corporate America itself could well form part of a constituency to move to individual-based health insurance. It has benefited from the tax exclusion. But it is not well served by the damage to morale and to employee relations generally that has come about because of the need to control health care costs – a need itself rooted in the tax-free way the nation has financed much of its health care. Being "the heavy" when an employee feels denied needed care for himself or a member of his family is not a role Corporate America could possibly want. Retaining a sponsorship role would foster employee welfare and, yet, end the hopelessly schizophrenic position corporations now find themselves in as administrators of health insurance.

Much the same constituency could be formed around a phase-in of an income-scaled tax credit, funded by a gradual reduction of the tax exclusion or a cap on the exclusion above the estimated cost of the basic plan. Phase-in could start, for example, by including all children – an approach that would appeal both to the Right's concern for "family values" and the Left's concern for care of the poor.

No health reform is apt to get very far, however, if it is framed in the basically dishonest public discourse of today. A tax credit or any other means of financing universal health care involves a redistribution of income. That has to be acknowledged from the start. The case for it can be made on grounds of efficiency and tax fairness. But it would be more convincing if the political establishment is willing to make the case for health care as a basic human right – not to be parceled out like Chevrolets or other goods and services best distributed only by the laws of the marketplace. That may be a novel approach in the context of a political debate that rarely seems to rise above appeals to narrow self-interest. But it might well fall on receptive ears if put forth in a forthright way.

# # #

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