

THE PRESIDENT'S 1992 HEALTH CARE WHITE PAPER: AN ECONOMIC PERSPECTIVE**

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ON February 6, 1992, President Bush submitted a proposal for comprehensive health care reform (*The President's Comprehensive Health Reform Program*, hereafter referred to as the White Paper). This paper summarizes some of the features of the President's proposals of interest to specialists in public finance. Before discussing aspects of the health insurance market and proposed reforms, it is worth remembering that the underlying market for medical care is not well described by the frictionless, competitive model of introductory textbooks. The market for health care is characterized by monopolistic and monopsonistic competition, principal-agent problems between patients and health care providers, and merit good aspects of medical care.

Two characteristics of problems in U.S. medical care are gathering significant public attention: *access* and *cost*. First, roughly 34 million Americans are estimated to have no health insurance, requiring them to seek care in emergency rooms. Second, the growth in medical costs is unsustainable. Medical expenditures are now about 12 percent of GDP, up from 5.3 percent in 1960. At this rate of growth in age-adjusted medical expenditures and after adjusting for changes in the average age of the population, medical costs would account for nearly one-third of GDP by 2020.¹

Much of the criticism of the American health care system—voiced in general and in the White Paper in particular—focuses on problems in the market for health insurance. Accordingly, I will focus on “access” and “cost” concerns in the health insurance market. The two concerns are related: with some exceptions, individuals are uninsured because the cost of health insurance exceeds the value indi-

viduals place on insurance coverage. In thinking about this, one must remember that a lack of health insurance and a lack of medical care are not the same thing. Some estimates suggest that the uninsured receive approximately one-half of the medical care they would receive if they were insured.² Why might individuals choose not to purchase health insurance? First, very low-income individuals have a high marginal utility of income, making health insurance unattractive, given the availability of uncompensated care. Second, some individuals—particularly the young—may simply not perceive the risky consequences of their action. Finally, some individuals find insurance too costly, deciding to self-insure because the premiums charged are high relative to premiums charged for similarly-situated individuals.

While the White Paper refers to underlying principles of “preserving choice” and “relying on the market,” it should be noted that “choice” and “the market” are associated with the current state of health insurance in the United States, which has led to “access” and “cost” concerns. If we as a society believe that the health insurance system should be privately organized, provide choice to consumers, be accessible to most citizens at a “reasonable cost,” and offer broad pooling of health risk based on social insurance principles (*i.e.*, that health status *per se* should not significantly affect an individual's insurance costs), then some forms of government intervention will be required. These principles are stated (explicitly or implicitly) in the White Paper and shape the interventions recommended.

The paper is organized as follows. It begins by reviewing the White Paper's proposals for access and cost containment. At the intersection of these two general characteristics, I then explore the White Paper's proposal to facilitate greater and less costly insurance coverage of small

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employer groups. Next, I contrast the general approach taken by the White Paper with some competing comprehensive reform proposals. I conclude with some observations regarding the policy debate of the White Paper's recommendations.

Expanding Access: Health Insurance Tax Credit

The principal "access" feature of the President's 1992 proposals is a new transferable tax credit and deduction to increase health insurance coverage. While the credit and deduction would provide the greatest benefit to low-income individuals, some benefits would also be available to middle-income individuals with little or no employer contributions for health insurance and to self-employed individuals. Any insurer selling coverage to individuals receiving health insurance tax credits would be prohibited from excluding any credit recipient from coverage.

Tax Credits and Deductions for Low- and Middle-Income Individuals

Under the President's proposal, low- and middle-income individuals not covered by Medicare, Medicaid, VA, or CHAMPUS plans would be eligible for a tax credit or deduction to be used to purchase health insurance. According to the White Paper, eligibility for the credit or deduction extends up to a modified adjusted gross income³ (MAGI) of \$50,000 for single persons, \$65,000 for persons filing as heads of households, and \$80,000 for married persons filing jointly. (These income levels would be increased with inflation using the CPI-U price index.) The credit would be transferable to employers or insurance companies for the purchase of health insurance. Under the plan, it would replace the supplemental earned income tax credit available under current law for certain low-income taxpayers contributing toward the purchase of health insurance coverage for their children.

The maximum amount of the credit would range from \$1,250 for single persons to \$2,500 for two-person families to \$3,750 for families of three or more. The

White Paper suggests that these credit amounts would be sufficient to purchase certain basic health insurance plans.⁴ As described below, the amount of the credit would phase down to a minimum as income rises.

Eligible individuals and families can claim an above-the-line deduction,⁵ instead of the credit available under the plan, ranging from \$1,250 for single persons to \$2,500 for two-person families to \$3,750 for families of three or more. Both the transferable tax credit and the deduction will be increased with inflation using the CPI-U index. In addition, credit and deduction amounts will be reduced by the amount of any employer contribution. Individuals receiving employer contributions greater than the applicable credit or deduction amount will not receive the tax credit or deduction.⁶

The White Paper provides a five-year transition period in which to phase in the transferable tax credit. When fully phased in, eligible amounts are given as follows. First, all eligible individuals and families with incomes below the tax-filing threshold⁷ would receive the maximum credit. Eligible individuals with MAGI between 100 and 150 percent of the tax-filing threshold would receive a partial credit declining linearly with MAGI, reaching a minimum level equal to 10 percent of the applicable maximum credit at 150 percent of the tax-filing threshold. Finally, eligible persons of families with MAGI greater than 150 percent of the tax-filing threshold would choose the more valuable applicable deduction or the minimum credit.

The amounts for the tax credit and deduction would be phased out linearly over the range (for MAGI) of \$40,000-\$50,000 for single persons; \$55,000-\$65,000 for two-person families; and \$70,000-\$80,000 for families of three or more. The Treasury Department's Office of Tax Analysis estimated that the annual cost of the credit and deduction when fully phased in in 1997 to be approximately \$35 billion (1997 dollars).

Administration of the tax credit and deduction is complex, and the White Paper offers only an outline of the solution.

Individuals filing a return could claim applicable credits and deductions on their returns as they would other credits and deductions. More difficult cases arise for nonfilers or for individuals needing advance certification of the credit to obtain insurance.⁸ The White Paper envisions that low-income recipients of the credit would obtain a certificate during the year by going to a designated governmental office to be selected by the individual states (e.g., Employment Service offices or a contract with the Social Security Administration). Such an office would certify eligible individuals and inform the Internal Revenue Service of any issuance of advance credits. Certificates for the transferable tax credit could then be taken to employers or insurance companies. Credits could be used to purchase a "basic benefit package" (which states would require insurance companies to issue) or other health plans of their choice.⁹

Credits and Deductions for Self-Employed Individuals

The President's White Paper proposes to extend and expand the current partial deductibility of health insurance premiums for self-employed individuals who could choose to receive the applicable credit.

Does the President's Plan Improve Access?

The Office of Tax Analysis estimated participation rates by eligible individuals for the health insurance tax credit and deduction proposed in the White Paper. When fully phased in, it is estimated that a total of about 90 million individuals would benefit. About 25 million of these beneficiaries would be low-income individuals receiving the maximum applicable credit. Another 10 million individuals with MAGI between 100 and 150 percent of the tax-filing threshold would receive a partial credit or deduction. Finally, 56 million middle-income individuals would receive a partial credit or deduction (generally a deduction). Self-employed indi-

viduals would benefit from the credit-deduction program.

Ultimately, of course, judging these estimates or any others requires an assessment of assumptions about participation rates and effects of comprehensive health care reform on health insurance and medical care costs. The next section reviews the White Paper's suggestions for cost containment in the section that follows.

Encouraging Cost Containment

Expanding access to health insurance without addressing underlying causes of spiraling health insurance (and health care) costs is not likely to be a viable strategy for "comprehensive" reform. The crux of the problem is this: the mix of medical care services provided is not necessarily that which fully informed consumers would purchase, and such services are not produced at minimum cost. The President's White Paper responds in a way that economists have generally responded (since Arrow, 1963; and Feldstein and Friedman, 1977), by focusing attention on problems in insurance markets. This argument incorporates aspects of moral hazard (i.e., that insurance for fee-for-service medical care with low cost sharing engenders excess demand for medical services) and the distortion of the perceived price of health insurance (owing to the favorable tax treatment under both the income and payroll taxes).¹⁰

This is not to say that relatively efficient forms of health insurance coverage are not possible in the marketplace. Options with "coordinated care" (in which the health plan purchases a package of health care through, say, a health maintenance organization at a lower cost than fee-for-service medicine) or fee-for-service coverage with deductibles and copayments are available. Three factors in the market for health insurance have probably reduced the demand for such alternatives, however. These factors include: the tax subsidies mentioned above; limited consumer information about the quality of services of health-care providers, forcing "price" to be taken as a measure of quality; and opportunities for favorable risk selection by

insurers in the marketplace.

The White Paper suggests that the provision of tax credits will encourage consumer choice among insurance options and that cost-conscious shoppers will be effective soldiers in the war for cost containment. This outcome is likely only with significantly better information for those consumers. The White Paper does indicate that state and local initiatives could provide information on the quality of local physicians and hospitals.¹¹ As with any market, it is not necessary that all individuals be informed. A minority of well-informed institutional and individual consumers can induce cost sensitivity in the market (see *e.g.*, Pauly, 1978).

Other proposals for cost containment include: (1) encouraging greater reliance on coordinated care (*e.g.*, health maintenance organizations or preferred provider organizations) in public programs such as Medicare and Medicaid; (2) eliminating state-level restrictions limiting coordinated care; (3) prohibiting physician self-referrals (*e.g.*, to diagnostic centers in which the doctor has a financial interest); (4) increasing funding for preventive medicine programs such as those for vaccine research, screening, and health education; (5) medical malpractice reform; and (6) insurance market reforms (particularly in the market for individual and small-group policies). Below, I discuss only the last option, both because of its general importance to comprehensive reform and because of the attention accorded it in the White Paper.

Increasing Insurance Coverage of Small Groups

At the outset, I noted that one reason for not purchasing health insurance was the possibility of very high premiums relative to those charged for similarly-situated individuals or groups. This cost and access problem is particularly severe in the market for individual and small-group policies. The White Paper proposes reforms of the small-group market aimed at: (1) increasing bargaining power (*vis-a-vis* insurers) of small employers and reducing the administrative costs they bear; (2)

encouraging broader risk pooling; and (3) assuring availability of coverage.

Health Insurance Networks

Small employer groups lack the group purchasing power of large employer groups. The White Paper encourages the development of Health Insurance Networks (HINs), which would act as group purchasing agents for members, obtaining more favorable premiums and reducing administrative costs. An oft-cited current example is Cleveland's Council of Smaller Enterprises, which operates a program for group purchasing of health insurance for small businesses. HINs were proposed in the White Paper to extend this pooling and group purchasing mechanism nationwide.

Explicit encouragement of HINs would occur through extending the federal preemption of state regulation of self-insured benefit plans (principally for large employers) under the Employee Retirement Income Security Act to small firms purchasing health insurance on a group basis through a HIN. Such a federal preemption would protect small firms from state-level mandates for certain health benefits and premium taxes (in excess of those used to fund solvency or guaranty funds). Each HIN would be a nonprofit organization with voluntary membership, and would be registered by the Department of Labor or a state agency, whichever is applicable.

Risk Pooling with Health Status Adjustments

The President's plan relies on privately-provided health insurance. While private health insurance can provide protection against unpredictable medical expenses, private markets will likely not facilitate pooling (from small groups) of individuals with low and high *ex ante* health care costs. One goal of the risk pooling proposal is to accomplish this broader pooling without resorting to premium regulation. Broader health risk pooling also makes less costly suggested regulations relating to renewability and

portability of health insurance (e.g., by avoiding "preexisting condition" rules).

A second feature of the President's proposals for small-group coverage relates to broader risk pooling. Two features of the proposal are noteworthy from an economist's perspective. The first relates to the social insurance principles involved. Aimed at the segment of the market most adversely affected by favorable risk selection by insurers ("cream skimming")—that for small group policies—risk pooling would be designed to make insurers indifferent to the health status of enrollees, but not indifferent to non-health-status differences such as age. The second relates to the scheduler character of reimbursements from the pool to insurers: specifically, insurers would receive reimbursements based on enrollees' health status during the period (more on this below) and not based on actual expenses, thereby exerting pressure on insurers to control costs.

Essentially, the health risk pooling proposal involves determination of each insured individual's health attributes—"health status"—and a relationship linking health status to net payments into a statewide risk pool. Net payments would be positive for low (*ex ante*) risk, and would finance net transfers to insurers of high (*ex ante*) risk individuals. That is, to restate the "social insurance" feature of the proposal, the system would entail taxes and subsidies contingent upon an individual's health status (and possibly contingent on the amount of insurance purchased). The proposal would place no restriction on benefit design premium structure, or underwriting standards for health insurance as a consequence of the risk pool. As discussed below, risk pool payments would be calculated based on a reference benefit package (not necessarily the actual benefit package purchased), and in equilibrium, the payments would tend to equalize the cost of insuring individuals differing only with regard to health status.

Each state would construct two broad health risk pools under the proposal—one for small-group coverage and one for coverage provided to individuals receiving

transferable health insurance tax credits. These pools would spread risk across health plans providing coverage for those groups within a state. Plans covering a healthier-than-average population would be net contributors to the risk pool, while insurance plans covering a sicker-than-average population would receive a transfer from the risk pool. Payments to and from the pool would be governed by the difference between expected health care costs for the covered population in the state and the expected health care costs for the insurer's covered population. As a result, in equilibrium, though premiums would not be regulated, premiums for coverage would be independent of health status.

The White Paper envisions that health risk pooling would be implemented on a state level for credit recipients and for participants in the small group market. In both cases, a mandate would be provided to ensure that all members of the defined population participate in the pool. In principle, risks could be pooled across or within demographic categories. The White Paper suggests strongly that health risk pooling not occur across age groups to avoid transfers from younger to older individuals.¹² It is possible to vary transfers according to a number of additional variables, including gender, geographic location, industry or occupational categories, or health habits (e.g., smoking). The important underlying premise is that adjustments do not depend on health status.

Two logistical issues complicate implementation of the health risk pooling proposal—design of individual health status adjustment factors and mechanisms for scheduler payments to insurers. I discuss these in turn below.

Each year, members of the pool's population would be divided into one of a number of mutually exclusive health status categories. The White Paper suggests that categorization could be implemented using diagnostic information already collected by health insurance plans on inpatient and outpatient claims. Indeed, applied research by public health specialists, statisticians, and economists has already produced methods for predicting health care costs based on the health character-

istics of the covered population. Leading examples include the Ambulatory Care Group system developed at Johns Hopkins University and the Diagnostic Cost Group developed at Boston University.¹³ The Department of Health and Human Services would fund technical and implementation research to develop workable health status adjustment systems for use by the states.

Second, payments to and from the risk pool could be prospective or retrospective. Prospective payments would be based on the health status adjustment factor determined before the service period for each enrollee, while retrospective payments would be based on the health status adjustment factor determined during the service period. There are advantages and disadvantages associated with each; the important point is that both payment mechanisms are based on expected, not actual, expenditures.

An example illustrating the operation of the health risk pool is instructive. Suppose that an eligible individual in one of the risk pools wants to purchase a reference benefit package at the premium charged. The premium would be paid to the insurer, though the amount ultimately received by the issuing insurer would be subject to a health status adjustment. Each eligible individual in the credit or small-group pools would be assigned to a health status category each year. Health status categories would be assigned a weight based on expected health care costs relative to the average for the covered population in the pool. The insurer in the example would compute an average weight for all individuals in the pool covered under its policies. If that average weight is less than the statewide average, the insurer would be required to make a contribution to the pool; if the insurer had an average weight exceeding the statewide average, it would receive a net transfer from the pool.¹⁴

The White Paper proposed that the states implement risk pooling and health status adjustment for transferable tax credit recipients at the outset of the credit program's implementation. Implementation in the small-group-coverage setting

would begin three years after the enactment of the President's package, and would be phased in over five years. During the transition period, premium standards ("bands") would limit variation in premiums within each insurer's set of benefit plans offered.

While the health risk pooling arrangement is one of the most significant reforms proposed in the White Paper (though the health insurance tax credit has received much more attention), it faces "boundary" problems in addition to the logistical concerns noted above. The proposal does not envision that there will be a single, comprehensive health risk pool for each state. Pools would form for tax credit recipients and for small-employer groups. Healthy individuals have an incentive to avoid participation in the health risk pooling system (either by not purchasing insurance or by obtaining insurance outside the pool). For example, if self-insured firms were not required to participate, healthy workers would have an incentive to work in self-insuring firms. In addition, as long as not all individuals are required to participate, there would be an incentive for individuals to delay purchasing insurance and entering the pools. Finally, if there were multiple pools (as would be the case if tax credit recipients and those insured in small-employer groups are pooled separately) with different payment formulas, participants may place themselves in the pool most desirable to them. While such boundary problems are not insurmountable, serious debate of the White Paper's health risk pooling proposal will need to address them.

Assuring Availability of Coverage

The President's plan outlines a set of initiatives to ensure that coverage is not denied to individuals or employer groups.¹⁵ First, insurers would be required to accept every employer group in the state that applies for coverage and to provide coverage for all individuals within a covered employer group. Second, employers would not be permitted to exclude an employee from health insurance coverage on account of his or her health status.

An additional "access" proposal in the President's plan relates to the renewability and portability of health insurance coverage (not restricted to those individuals benefiting from the health insurance tax credit or deduction). As part of the reform of the insurance market for small employer groups, insurers selling group coverage in a state would be required to renew coverage for a group except in the case of non-payment of premiums, fraud, or misrepresentation. In addition, workers would be able to change jobs without loss of coverage due to a preexisting coverage exclusion. This elimination of preexisting-condition provisions will increase mobility across jobs for many workers.¹⁶

Finally, to reduce non-coverage of new entrants to the workforce, the President's plan would require all colleges or universities providing group health insurance to students to extend that coverage for six months after completion of undergraduate or graduate programs. The plan would not, however, require the college or university to contribute toward the cost of such health insurance coverage.

Contrasting the President's Plan with Other Approaches

National Health Insurance and Play-or-Pay Proposals

While I will not discuss these alternatives in any detail, the White Paper notes that the Administration's Health Policy Working group rejected at the outset "national health insurance" and "play-or-pay" alternatives. Under a national health insurance system, such as the Canadian system, health insurance is provided to all citizens through a centralized program, while health care services are provided in the private sector with negotiated reimbursement by the government. Under play-or-pay schemes, employers would be required to provide health insurance for workers and dependents or pay a payroll tax to fund public insurance for their workers and dependents.

Two basic problems with Canadian-style

national health insurance plans were stressed in the White Paper. The first is that, owing to the fact that medical care is free, recipients of health care in the Canadian system lack incentives to reduce costs (either through cost sharing or innovative delivery options). Second, the government uses overall supply-side controls to cover costs; macro-level budget constraints need not insure that appropriate incentives and information are brought to bear in individual decisions. Reliance on supply constraints has led to queues for some treatments, and delays in treatment have been blamed for significant costs in terms of loss of productivity (see e.g. Danzon, 1991).

There are a number of problems with play-or-pay proposals. First, while such schemes would increase access to health insurance, they would lead to lower take-home pay for workers in the long run; a mandate cannot force an employer to pay workers more than the value of their marginal product.¹⁷ In the short term, employers, including many small businesses, will bear much of the burden of the mandate. Second, play-or-pay plans are likely to serve as a segue to national health insurance. Absent additional reforms, health care costs are likely to grow faster than wages. Accordingly, unless the payroll tax rate is increased, the public plan will become more underfunded. The political process is unlikely to generate regular payroll tax increases. As a result, as the public plan becomes less costly relative to private insurance, employers will switch into the public plan.

Tax Caps and Tax Credits

Proposals for comprehensive health insurance reform by conservative economists have generally approached the problems of "access" and "cost containment" by radically altering the tax treatment of health insurance.¹⁸ A stylized characterization is as follows: while employers could continue to deduct as a business expense any contributions for health insurance, any such benefit would be includable in employees' incomes (a "tax cap" of zero).¹⁹ The resulting decrease in

the tax expenditure for health insurance (about \$60 billion for FY 1993) could be used to finance refundable tax credits for the purchase of health insurance by low- and moderate-income individuals. Such a proposal offers expanded access through the refundable tax credits and cost containment by raising the after-tax price of health insurance, reducing the demand for medical services.

The availability of tax credits for low- and moderate-income individuals can lead to high effective marginal tax rates as those credits are phased out. This problem is true over certain narrow income ranges in the President's proposal as well, and reflects a tradeoff between reducing distortions of work incentives from high marginal tax rates and the high cost (which, of course, must be financed with distorting taxes) of making tax credits phase out over a broader income range.

Implementing a tax cap with no reforms in insurance markets is a blunt means of controlling medical costs. The efficiency-enhancing properties of a tax cap are based on the assumption that more expensive plans are necessarily more generous. There are three problems with this characterization, all of which stem from the fact that privately-purchased medical insurance is organized primarily as employer-provided group insurance. First, as noted earlier, selection problems can result in very high insurance premiums for some groups (particularly small employers). Second, there are important differences in administrative expenses (and, as a result, insurance load factors) across employer-based groups, ranging from an estimated 40 percent of benefit costs with 1-4 individuals to about 5.5 percent for groups of at least 10,000 individuals (see Diamond, 1991). Third, individuals require information to be intelligent shoppers for health insurance. The President's proposals focused more on reforms in these areas, rather than emphasizing a tax cap. In addition to these problems, geographical variation in the cost of medical services complicates the definition of a fixed-dollar tax cap.

Diamond's Federal Health Insurance System

Diamond (1991) has proposed a comprehensive health insurance reform similar to the President's in some respects, but with some significant differences. As did the White Paper, Diamond stresses the importance of group purchasing arrangements. However, he would add a government-sponsored Federal Health Insurance System (modeled on the Federal Reserve System), which would assign individuals to "groups" based on geographical location. Regional Federal Health Insurance System offices would bargain with insurers to offer a menu of policies. Similar to the risk pooling approach suggested by the White Paper, individuals under Diamond's proposal would pay premiums based on location or policy choice but not based on health status. Unlike the President's proposal, however, premiums would be collected through the income tax system,²⁰ and very low-income individuals would receive assistance for purchasing insurance from Medicaid. The advantage offered by formal government intervention through the Federal Health Insurance System relative to a system with HINs and health risk pooling is not clear.²¹ Diamond offers no specific proposals for cost containment, but suggests a possible cap on reimbursements (which one could compare with the schedular reimbursement in the President's plan based on health status adjustment).

Concluding Observations

This paper has provided only a limited review of President Bush's health care White Paper, focusing on access and cost containment. Let me close with four observations regarding future debate of the President's plan:

(1) *There is no free lunch.* In the short run (and possibly in the long run), significantly expanded access to health insurance is likely to be costly. Insuring the currently uninsured is expensive, though the cost would be reduced by scaling back current federal payments for uncompensated care. Moreover, to the extent that

the risk pooling proposal with health status adjustments increases the number of individuals with coverage, average premiums paid by those currently covered may well rise.

In the course of the debate over the President's proposal, mandates for health insurance coverage for individuals will no doubt be suggested. A mandate for individual insurance coverage—e.g., requiring some basic benefit plan—offers an advantage of broadening the pool of enrollees for sharing risk. Such an alternative could resemble Diamond's proposal without the imposition of the government-sponsored Federal Health Insurance System. However, to be feasible in the context of the President's proposal, such a mandate would have to be accompanied by more complete provision of health insurance tax credits to low-income individuals. In addition, to avoid regulation of premiums charged by insurers, funding for such tax credits may have to increase more rapidly in the short run than envisioned by the President's health care policy working group.

(2) *Some regulation cannot be avoided.* Proposals to expand access to health insurance in the small group market at a reasonable cost necessarily involve regulatory intervention. Absent such intervention, favorable risk selection by insurers is unlikely to end. Regulation should seek to promote the basic social insurance principles in the President's proposal discussed earlier, and should not attempt to mandate particular benefits or set premiums.

(3) *At some point, the open-ended tax subsidy for employer provided health insurance will have to be examined.* The current subsidy encourages consumption of medical services and is distributionally inequitable, conferring no benefits to low-income workers without insurance and considerable benefits to affluent employees. Addressing this issue will nonetheless be difficult; a tax cap set at a value other than zero will involve significant definitional questions.

(4) *Information collection and dissemination will be important components of comprehensive reform in the search-inten-*

sive health care market. Attention should be focused on direct dissemination to individuals and on group purchasing arrangements (to communicate information to small employers) as suggested in the White Paper.

The President's White Paper addressed problems of access and cost containment in health insurance, with proposals for significant changes in current health insurance arrangements. Its success, if adopted, will likely depend on how well it can adapt to the concerns raised in these observations.

ENDNOTES

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¹More detailed discussion of rising health care costs can be found in the White Paper, Darman (1991), and Aaron (1991).

²For a discussion of effects of implicit or explicit social insurance on saving or private insurance, see Hubbard, Skinner, and Zeldes (1992).

³Modified adjusted gross income is defined as the sum of adjusted gross income, nontaxable Social Security payments, Railroad Retirement payments, and tax-exempt interest.

⁴This assumption is important when estimating participation rates as well as assessing potential problems of adverse selection for insurers offering plans to this group.

⁵That is, the deduction is available without regard to whether the filer itemizes or takes the standard deduction.

⁶The implementation of the tax subsidy through a deduction was to reduce the likelihood that employers would drop coverage. With a deduction, there is no incentive for an employer to drop coverage in equilibrium. Both wages and health insurance contributions are fully deductible to the firm. If the firm reduced coverage by \$X and increased wages by \$X, the employee's taxable income would rise by \$X. However, the new above-the-line deduction reverses this effect (for income tax purposes). Since individuals at or below the tax-filing threshold would receive no benefit from a deduction, a credit was offered instead. Formal revenue estimates provided by the Treasury Department's Office of Tax Analysis incorporate effects of some degree of reduced employer coverage for this population.

⁷Since the credit and deduction are to be operated through the tax system, the tax-filing threshold (the sum of the standard deduction and taxpayer and dependent exemptions) is designed to approximate the poverty level.

⁸Related issues have arisen in the context of the Earned Income Tax Credit; for an analysis, see Holtzblatt (1991).

⁹Credit recipients would also be placed in a "health risk pooling" arrangement by the states. Such ar-

rangements are described later.

¹⁰For discussion of the interaction of the tax subsidy and moral hazard issues, see Burman and Rodgers (1992).

¹¹The Health Care Financing Administration already publishes mortality rates and other data on hospital performance. A decision regarding publication of similar data for doctors is under review by the agency.

¹²To the extent that *ex ante* health status is correlated with age, some transfer will occur.

¹³See, for example, Weiner (1991) and Weiner, *et al.* (1991).

¹⁴Insurers would probably still participate in private reinsurance arrangements.

¹⁵In the White Paper, these initiatives were designed to apply to all private health insurance coverage; subsequent discussion has focused principally on the market for coverage for small employer groups.

¹⁶Atrostic and Burman (1990) argue that job mobility is reduced in a system in which large employers have low insurance costs relative to small employers.

¹⁷Empirical research has borne this out in analyzing other mandates (see *e.g.* Gruber and Krueger, 1990).

¹⁸See for example Pauly, *et al.* (1991) or Butler and Haislmaier (1989).

¹⁹Non-zero tax caps were proposed by President Reagan in 1982, and by the Treasury Department in 1984. No limit on the deductibility of employer contributions for health insurance was enacted in the Tax Reform Act of 1986. Tax caps were discussed as an option in U.S. Department of the Treasury (1990).

For a review of the literature on effects of the tax treatment of health insurance on the demand for insurance and medical services, see Pauly (1986).

²⁰Alternatively, Diamond suggests that premiums could be financed in part by a payroll tax on employers and in part from general revenues.

²¹If, for example, all individuals ultimately participated in the health risk pools with health status adjustments, the President's proposal would reach the social insurance scheme suggested by Diamond, but with large employers and HINs performing the bargaining function Diamond assigned to the Federal Health Insurance System.

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