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Policy Analysis

RESTORING HEALTH FREEDOM

The Case for a Universal Tax Credit for Health Insurance

by Sue A. Blevins

Executive Summary

During the debate over the Clinton health care plan, opponents of "ClintonCare" pointed out that the plan would force Americans into restrictive managed-care plans with limited choices. First Lady Hillary Rodham Clinton and others pointed out, correctly, that many Americans are already finding their freedom to choose a health care provider restricted. In fact, 48 percent of U.S. workers report that their employers offer only one health care plan. Those plans increasingly are health maintenance organizations or other types of managed care with limited options.

The main reason for the present situation is that federal tax law favors employer-sponsored health insurance. Employer-sponsored health insurance is fully excluded from taxation, but individually purchased health insurance is not. The result is that individuals have diminished ability to choose their health care plans, providers, and treatments.

Americans' lack of health freedom can be measured objectively using the Health Freedom of Choice Index. This study uses that index to compare three types of health insurance plans: the Federal Employee Health Benefits Program, Medicare, and medical savings accounts (MSAs). According to the index, MSAs offer individuals the most freedom to select their health care providers and benefits. Last year's Kassebaum-Kennedy bill limited the number of MSAs to 750,000 nationwide. This year Congress will grant the MSA option to only 390,000 of 37 million Medicare recipients.

The way to restore freedom in health care is to provide every American a tax credit for health insurance, whether purchased privately or through an employer or other organization. A universal tax credit, along with legislation to make MSAs available to all Americans, would help put choices about health care coverage back in the hands of the people.

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Introduction

Few issues in health care have as much resonance with the American public as the freedom to choose one's doctor or health care provider. Indeed, concern about restrictions on the free choice of provider was one of the major reasons for the defeat of the Clinton health care plan. Today, the importance of that issue can be seen in the anxiety over managed care and its restrictions.

There is good reason for Americans to be anxious. In one sense, of course, we remain free to choose any health care provider we wish--if we are willing to pay for it. However, in practice, government policies are increasingly limiting our choices.

The most visible of those government policies is the increasing number of state laws and federal reimbursement regulations that directly restrict patient access to the full range of available health care services, including midwives, nurse practitioners, and chiropractors.[1] Regulations also limit consumer access to nontraditional treatments such as acupuncture, homeopathy, and massage therapy.[2] However, a less obvious government policy may have an even greater impact on the freedom to choose the provider of one’s choice. Following World War II, the federal government established a tax law that favors employer-sponsored health insurance, while penalizing individuals for purchasing private health insurance. The value of employer-provided insurance is excluded from the employee's gross income and is therefore untaxed. However, workers who purchase their own health insurance or who purchase health care out of pocket receive no tax break. They must purchase health insurance (or health care) with after-tax dollars, which dramatically increases the effective cost of the insurance or health care.[3]

As a result of that bias in the tax code, most people have been subtly coerced into relying on third parties such as employers and governments to pay health care bills, even for routine care. Third parties paid 77 cents of every dollar spent on health care in 1990.[4] That means that third parties decide what types of health benefits are covered for most Americans. After all, he who pays the piper calls the tune, and since employers and governments are paying the health care bills, they get to decide what is covered.[5]

Because the tax code penalizes individuals who purchase insurance for themselves, most workers rely on employer-provided insurance. As a result, however, those workers are limited in the

type of insurance they receive and the type of provider that the insurance covers. In fact, 48 percent of U.S. workers report that their employers offer only one health care plan.[6] Those plans often are health maintenance organizations (HMOs) or other types of managed care that limit the available number of physicians and treatments.

Congress has responded to this problem by attempting to mandate the type of providers and services reimbursable by health insurers. In 1996, for example, Congress mandated that insurers provide coverage for at least 48 hours of maternity care. A host of additional mandates is pending. But mandating insurance benefits is not a solution: Adding additional services drives up the cost of insurance, causes some individuals and employers to drop their insurance, and ultimately increases the number of uninsured persons.

The way to truly restore health freedom is not to treat the symptoms through mandated benefits but to cure the underlying disease by eliminating the tax bias against individually purchased health insurance. That will give individual consumers control over their health care dollars, thus restoring their freedom to choose their health care providers.

Who Really Pays for Health Insurance?

Who really pays for employer-provided health insurance? Employees and taxpayers do. Most people accept limited health care choices because they think someone else--employers or government--is paying for their health insurance. But that is a misconception. As is true of every other commodity or service, there is no such thing as "free" health insurance. Employer-sponsored health insurance plans lead employees to believe they are getting free coverage, but economists show that workers actually forgo higher wages in lieu of health benefits.

Economist Charles Phelps argues that "every dollar paid for health insurance is a dollar not paid in wages. This means that workers want to be careful in their selection of insurance, because they really are paying for it, even if the employer is making the payments on paper."[7] John Goodman, president of the National Center for Policy Analysis, puts it this way:

> Health insurance is a fringe benefit which substitutes for wages in the total employee compensation package. The more costly health insurance becomes, the smaller

> the remaining funds available for wage and salary increases. The ultimate victims of waste in the medical marketplace are employees. This is one reason why take-home pay has been relatively stagnant over the past two decades, even though total compensation has been rising.[8]

Although workers' total compensation has increased over the past few decades, Goodman notes that workers' take-home pay actually fell by 6 percent between 1973 and 1991, during which time employer-sponsored health insurance benefits increased. Table 1 shows the decline in take-home pay relative to increased employer spending on health benefits between 1970 and 1991.[9] Workers--not employers--clearly bear the burden of high health care costs in the form of lower take-home pay.

A study by the Center for Health Economics Research explains why workers bear most of the burden of high health care costs and mandates.

> When faced with higher health care costs, businesses have three choices: (1) raise prices--placing the burden of higher costs on consumers; (2) accept lower profits--putting the burden on owners of companies; or (3) reduce wages and other labor compensation--shifting the burden to employees.[10]

Only the third of those choices is truly feasible because businesses find it difficult, if not impossible, to raise prices in a competitive marketplace and are unlikely to accept reduced profits in the long run.

Workers also bear the burden of high health care costs by relying on third parties. When people rely on a business or other third party to pay for medical care, they consume more health care services than they would if they were paying for them directly.[11] The following scenario demonstrates how that occurs. A group of coworkers decides to celebrate for the holiday by going out to dinner. They agree ahead of time to split the restaurant bill evenly among all workers. Paying for food collectively means that some people will order more food than they would if they were paying separately. For example, the nondrinker who doesn't normally order dessert does so because he wants to "get his money's worth," especially since the rest of the group is ordering wine. If the workers continued to dine as a group, eventually someone would complain that costs are

Table 1
Components of Employee Compensation: 1970-91 ($)

Year	Employer-Provided Health Benefits	Retirement and Other Nonhealth Benefits	Wages and Salaries
1970	829	2,368	26,956
1973	1,056	3,004	28,081
1979	1,439	3,487	26,831
1988	2,048	2,831	27,394
1991	2,394	2,592	26,758

Source: Jerry Cromwell et al., The Nation's Health Care Bill: Who Bears the Burden? (Waltham, Mass.: Center for Health Economics Research, 1994).

Note: The amounts shown reflect average compensation per full-time equivalent employee in private industry in 1991 dollars.

too high. Sooner or later, there would be limits placed on the choices of foods and drinks that could be ordered.

Because the third-party dynamic increases spending, some economists argue that it is more efficient to purchase health care individually. For example, Eugene Steuerle, a senior fellow of the Urban Institute, stresses that individual financing of health insurance makes the cost of health care more obvious to people and leads them to demand more for their money. Steuerle notes that financing health insurance individually will increase the efficiency of the market. "In the long run, you'll get a better level of medical goods and services for less money."[12]

Because they rely on third parties, Americans are paying higher prices for fewer choices. Today, a health insurance plan offered by a smaller business (50-199 workers) costs on average $4,848 for families and $1,932 for individuals. Annual health insurance premiums for larger employers (1,000 or more workers) run $5,400 for families and $2,067 for individuals.[13] Those figures do not include hidden health care costs, such as federal payroll taxes for Medicare Part A, general tax revenues for Medicare Part B, and state and local taxes that support community hospitals and clinics. All told, the hidden cost of health care is well over $8,000 per household.[14]

Why Do Americans Rely on Employers to Finance and Manage Health Insurance?

Conventional wisdom maintains that people purchase health insurance through employers to obtain a group rate. But that is not why businesses initially got involved in financing and managing employee health insurance. U.S. businesses first got involved in health insurance because of government price controls. The federal government froze industrial wages during World War II, forbidding companies to increase wages.[15] The price controls, however, did not apply to fringe benefits. Businesses found that the only way to legally compensate workers at increased rates was to increase fringe benefits, one of which was health insurance. Businesses continue to finance many workers' health insurance benefits. In 1994 nearly 53 percent of all employees were enrolled in an employer-sponsored or union-backed group health plan.[16]

There are some financial advantages for insurers and workers in purchasing health insurance through employer-sponsored group plans. Washington Consumers' Checkbook, a nonprofit organization that evaluates health plans, summarized those advantages:

> Some health plans offer coverage at lower rates to employed groups than to individuals. The plans offer these better rates because they believe employed persons are less likely to be sick than are persons who aren't working. Also, they know that by insuring a group they can expect to get some healthy individuals, not just unhealthy individuals who particularly want insurance. In addition, they allow for the fact that dealing with a group rather than individuals reduces administrative costs.[17]

Today, however, the ever-increasing costs of health care are leading businesses to reconsider their role in financing health insurance. The number of businesses that finance the total cost of health insurance has declined over the last decade. In 1980, 74 percent of employers who provided health insurance financed the entire package--that is, they did not require any employee contributions. By 1993 that number dropped to 37 percent.[18]

How the Tax Code Distorts the Health Care Market

While there is no doubt that Americans have lost control over their selection of health care benefits during the past decade, some economists argue that Americans have voluntarily given up their health freedom. They claim that if employees do not like the choice of providers and treatments covered under their employer-sponsored health insurance plan, they are free to buy another plan. For example, it has been noted that federal employees voluntarily purchase their health insurance through the Federal Employee Health Benefits Program (FEHBP).[19] No law requires federal employees or other workers to purchase health insurance through their employers. But the current tax law does force workers to pay higher taxes if they buy health insurance on their own.[20] Table 2 shows that a worker earning $25,000 per year would have to pay $540 more for health insurance if he purchased it individually rather than through his employer. In that way, the government manipulates the health insurance market, making employer-based insurance the preferred option for workers.

The major problem with today's health insurance tax law is summarized by Rashi Fein, professor of the economics of medicine at Harvard Medical School:

> The influence of the way the tax system allocates its rewards and exacts its penalties should never be underestimated. Just as home ownership is stimulated by the deductibility of mortgage interest and local property tax payments, so the development of health insurance was stimulated by the tax code. But in addition, the code provided an incentive that shaped a particular (and inequitable) set of institutional arrangements. It did not assist individual enrollment or even group enrollment per se (such as neighborhood, religious, or fraternal associations). Rather, it subsidized the purchase of health insurance only when the employer paid the premium. It thus linked health insurance to employment. In doing so, the tax code molded the nature of American health insurance, its availability and distribution. In extending benefits to some, the tax code discriminated against others.[21]

Nobel laureate economist Milton Friedman explains that the current tax law affects the cost and choice of health care benefits in two ways: (1) It leads workers to rely on employers, rather than themselves, to finance and manage

Table 2
Income Taxes Paid for Purchase of Health Insurance: Individual Earning $25,000 per Year

How Is Health Insurance Purchased?	Income Taxes Excluded for Purchase of Health Insurance	Income Taxes Paid for Purchase of Health Insurance	Final Cost of Health Insurance
Employer pays for health insurance	$540	0	$1,932
Worker pays for health insurance	0	$540	$2,472

Note: Total income tax estimated at 28 percent based on the following tax rates: 15 percent federal income tax, 6.2 percent Social Security payroll tax, 1.45 percent Medicare payroll tax, and 5 percent state tax. Cost of health insurance is based on a premium of $1,932 per year. Individuals can deduct the cost of health care (including insurance premiums) that exceeds 7.5 percent of adjusted gross income.

health care. (2) It leads workers to take a larger fraction of total compensation in the form of health care. Friedman concludes,

> If the tax exemption [for health insurance] were removed, employees could bargain with their employers for higher take-home pay in lieu of health care, and provide for their own health care, either by dealing directly with health care providers or through purchasing health insurance.[22]

The current tax law also encourages workers to join HMOs. In cases in which employers offer insurance only through an HMO,[23] workers are forced to choose the HMO or forgo the tax exclusion for health insurance altogether.[24] Thus, most people accept the health insurance plans offered by their employers, even if that means joining an HMO. Scott Holleran, executive director of Americans for Free Choice in Medicine, notes,

> Government virtually created managed care in the form of HMOs and encourages them through a tax code that forces Americans to get their health insurance through their employer. Don't blame the market for what the government has done to our system. The free market didn't create HMOs; government did.[25]

The growth in HMOs did not occur in the free market; it was spawned by federal legislation in 1973.[26] Backed by the Nixon administration and Sen. Edward Kennedy (D-Mass.), the HMO legislation required employers to offer workers the option of joining an HMO.[27] The number of Americans enrolled in HMOs grew

from 6 million in 1976 to more than 46 million in 1995.[28] Today, some 70 percent of private employees are enrolled in some form of managed care.[29] Keep in mind that employers often determine the price a worker pays for health insurance, so employers can set prices that encourage workers to join HMOs. The true demand for HMOs remains unknown, given that the federal tax law and HMO legislation have distorted the market.

The Health Freedom of Choice Index

While consumers have long known that their choice of health care providers and treatments has become increasingly restricted, there has been no objective way to measure that loss of freedom. In an attempt to develop such an objective measure, this study introduces the Health Freedom of Choice Index. The Health Freedom of Choice Index can be applied to health insurance plans, state laws, and federal reimbursement regulations.

In designing the Health Freedom of Choice Index, questions were developed to capture information about the consumer's freedom to choose (1) the most commonly covered health care providers and treatments and (2) alternative providers and treatments that are in high demand in the United States. The services and providers listed are those most commonly mandated by state governments.[30] Since it can be presumed that the state legislatures were at least partly responding to pressure from their constituents, such mandates can be used as a rough proxy for the services most often demanded by consumers but not covered under many available insurance policies.

Physician services are the most commonly used health care service, accounting for $189 billion in 1994.[31] Other commonly used health care providers, including chiropractors, nurse midwives, nurse practitioners, optometrists, physical therapists, and psychologists, accounted for $49 billion during that same year. The sale of prescription drugs reached a record high of $56.7 billion in 1994.[32] Accordingly, the Health Freedom of Choice Index measures access to prescription drugs as well as access to treatments prescribed by traditional health care providers such as optometrists, physical therapists, and psychologists. The Health Freedom of Choice Index is contained in Appendix 1.

The Health Freedom of Choice Index relies on objective reports that can be confirmed by a number of outside sources, rather than consumer ratings, to ascertain information about one’s

freedom to choose in health care.[33] Consumers, employers, health benefit managers, and others who have access to objective health care information (e.g., health plans, state laws, and federal reimbursement regulations) can use the Health Freedom of Choice Index.

Applying the Health Freedom of Choice Index

In an attempt to measure Americans' health freedom, this study applies the Health Freedom of Choice Index to three health insurance systems: (1) FEHBP, (2) Medicare, and (3) MSAs. This study examines national health plans and HMOs offered to federal employees during 1996. It does not compare state-based health plans because those plans are affected by state insurance laws, which vary greatly among the 50 states.

The FEHBP health insurance program is popular with congressional Democrats and Republicans. Both parties have proposed expanding the FEHBP as a way to increase health insurance coverage.[34] The FEHBP, which provides health insurance for approximately 9 million Americans, is touted as a premier health insurance system.[35] For example, Washington Post columnist James Glassman wrote recently that the FEHBP is probably the best insurance system in America because employees get to choose the types of health care services that are important to them.

> Some [FEHBP health insurance] plans allow one month of inpatient mental health care; some six months. Some pay for chiropractors; some don’t. The choice is up to the employee, who pays more for a more comprehensive plan.[36]

But upon closer examination, FEHBP plans offer only limited health care choices--not true free choice. For example, many of the so-called comprehensive plans that claim to cover chiropractors actually limit the number of visits or cap the annual amount reimbursable for chiropractic services. Forcing individuals to choose from a limited selection of federally regulated health plans, as is the case with FEHBP, will not restore health freedom in America.

FEHBP Fee-for-Service Plans

The FEHBP offers 13 national fee-for-service plans to approximately 5.4 million federal employees.[37] This study examined 8 of those plans, including Alliance, Beneficial Association of Capitol Employees, BlueCross BlueShield, Government Employees Hospital Association, Mail Handlers, National Association of Letter Carriers AFL-CIO, Postmasters, and Special Agents Mutual Benefit Association.

According to the Health Freedom of Choice Index, the federal fee-for-service plans do not offer truly free choice of services and providers, since the plan scores ranged from 60 to 75 out of 100 possible points. The major reason for the relatively low scores is that all those fee-for-service plans limit coverage for mental health benefits. They also restrict coverage for chiropractic services. Four of the plans claim they cover chiropractic services, but three of them restrict the number of visits or amounts paid for those services. Another plan limits coverage for chiropractic services to federal employees who live in one of 11 designated states. The data show that federal employees do not have true health freedom, even under fee-for-service plans.

FEHBP HMOs

Supporters of the FEHBP boast that the program offers 400 health plans nationwide, but they neglect to mention that 376 of the FEHBP plans are HMOs. Eight large insurance companies own nearly half the HMOs in the country.[38] That means that workers have very few choices in terms of what is covered, since employers and insurance companies generally dictate the terms of coverage.

To date, approximately 3.6 million FEHBP subscribers are enrolled in HMOs.[39] This study examined health care choices offered by 10 HMOs in the Washington, D.C., area. That area was chosen because it employs the largest number of federal civilian workers, some 17 percent of all government employees.[40] The following HMO plans were examined: Aetna Mid-Atlantic, Carefirst, CIGNA, Columbia Medical, HeathPlus, Free State, Humana, Kaiser Mid-Atlantic, M.D. IPA, and Prudential Mid-Atlantic.

According to the Health Freedom of Choice Index, the HMO health freedom scores ranged from 45 to 60 out of 100 possible points. Those scores are similar to the fee-for-service scores, notably because HMOs offer greater coverage for routine treatments

such as physical and eye examinations. But compared with fee-for-service plans, HMOs offer less freedom to choose one's health care provider. All of the Washington area HMOs require individuals to go through a primary-care gatekeeper before seeing a specialist. Ten of the HMOs restrict or limit access to midwives. Only one HMO includes coverage for chiropractic services, and that plan restricts the number of visits and selection of chiropractors. Clearly, federal employees' health freedom is restricted by both fee-for-service and HMO plans even though HMOs impose greater restrictions on employees' choice of providers.

Medicare

Nearly all Americans are forced by law to pay for the Medicare program, the taxpayer-funded health program for seniors. Although many taxpayers may not realize it, Medicare is not "insurance" in the true sense of the word, because neither the government nor any other party assumes the financial risk of future health care costs of Medicare beneficiaries. Rather, Medicare is a pay-as-you-go system whereby the government collects money from taxpayers and then contracts with 68 insurance companies to process Medicare claims for 37 million Americans.[41] All told, Blue Cross and Blue Shield plans process about 90 percent of Medicare Part A claims and about two-thirds of all Part B claims.[42]

What is more, since Americans do not have a "Medicare contract" with the federal government, there is no guarantee that tomorrow's Medicare program will cover the health care benefits that taxpayers are contributing toward today. Instead, the federal government gets to determine what types of health care providers and treatments are covered under the Medicare program. In some cases, the federal government does not specify coverage and instead allows the 68 insurance companies that process claims to decide whether a provider or treatment should be covered. Consequently, Medicare seriously curtails Americans' health freedom.

Medicare scored just 45 points on the Health Freedom Index. The primary reason for that low score is that Medicare does not cover preventive care and restricts access to many health care providers. For example, Medicare does not pay for physicals, eye examinations, or foot care.[43] Medicare also does not cover most prescription drugs. According to the U.S. Department of Health and Human Ser-
vices,

> Most of the services covered by Medicare must be provided by either a doctor of medicine or a doctor of osteopathy. Under very limited circumstances, Medicare can help pay for services of chiropractors, podiatrists, dentists, and optometrists. As an example of how restrictive the coverage is, there is only one chiropractic service covered by Medicare. That is manipulation of the spine to correct a dislocation that can be shown by an X-ray. Medicare does not pay for an X-ray performed by a chiropractor [even though chiropractors are licensed to perform X-rays in all 50 states].[44]

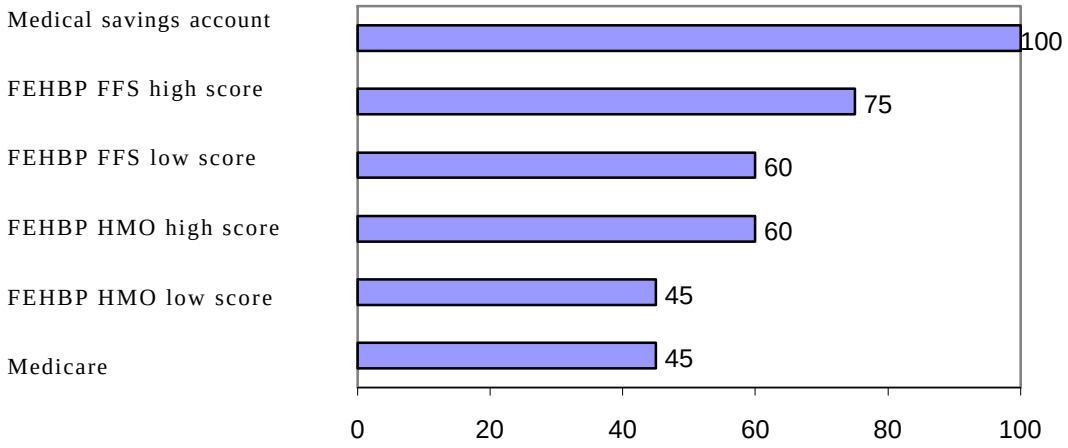
The Health Freedom of Choice Index clearly shows that Medicare limits seniors' access to many types of providers and restricts coverage for medical treatments, including prescription drugs.

Medical Savings Accounts

Medical savings accounts (MSAs) are tax-free savings accounts from which individuals withdraw funds to pay medical bills and related health insurance deductibles. To establish an MSA, workers or their employers take a portion of the sum currently spent on traditional health insurance policies (an average of $1,932 per person), and instead purchase high-deductible catastrophic health insurance policies, which typically cost less than $900 per person.[45] The other portion (approximately $1,032 per person) is then deposited into each worker's individual MSA. Workers can use the MSA funds to pay for any medical expenses. The catastrophic insurance policy becomes effective after the annual deductible is met. Any remaining funds can accrue from year to year and can be spent on any qualified medical expense listed in Internal Revenue Code section 213(d). The list of tax-deductible medical expenses is very broad; Appendix 2 lists some of the categories of eligible medical expenses. In addition, MSA funds earn tax-free interest and can be withdrawn at retirement.

As measured by the Health Freedom of Choice Index, MSAs give consumers the most freedom to choose their health care providers and treatments. MSAs scored a perfect 100 points, covering all of the providers and treatments listed on the Health Freedom of Choice Index. Figure 1 shows how MSAs compare with the FEHBP and Medicare. It is important to note that this analysis applies only to the portion of

Figure 1
Summary of Health Freedom of Choice Index Scores



Note: 0 = no health freedom of choice; 100 = maximum health freedom of choice. FEHBP = Federal Employee Health Benefits Program, FFS = fee-for-service health, HMO = health maintenance organization health plan. It is important to note that this analysis applies only to the portion of health care expenses paid out of the MSA. The catastrophic insurance policy may contain restrictions on coverage.

health expenses paid out of the MSA. The catastrophic insurance policy may contain restrictions on coverage.

Congress unfortunately has limited MSAs to 750,000 Americans of working age and 390,000 Medicare recipients.[46] Congress could not have chosen a worse time to restrict the MSA option. Health care costs are skyrocketing, and, at the same time, consumers are frustrated by their lack of health freedom. Congress must either trust people to ration their own health care dollars or face a strong consumer backlash in the form of calls for more mandated health benefits, which will compound the problems of the current system. That is already happening in the states and at the federal level.

As long as it appears to consumers that someone else is paying for their health care, they will inevitably demand as many health care benefits as possible. And as long as employers are restricting the choice of health plans, consumers will continue to fight for their choice of mandated health benefits. That is why Congress should seriously consider removing the cap on MSAs. If it does not, workers will continue to bear the burden of

increasing health care costs.

Mandated Health Benefits and Health Freedom

Frustrated by the lack of choice among health insurance plans, Americans are turning to mandates in an attempt to meet their health needs. Today there are more than 800 state mandates.[47] More than 25 states have enacted laws known as "any willing provider" laws that prevent HMOs from forming exclusive networks of providers.[48] Mandated health benefits are also making headway on the federal level. Congress recently enacted mandates for mental health parity, minimum maternity hospital stays, and guaranteed issue and portability.[49] More than a dozen mandated benefit proposals and anti-managed-care restrictions are pending before Congress as of this writing.[50]

Health insurance mandates do not offer something for nothing. Mandating additional health services drives up the costs of health care, increases the number of uninsured persons, and lowers wages. In Patient Power, John Goodman and Gerald Musgrave note that when routine dental care was mandated, the average premium for health insurance increased by 23.8 percent.[51] The increased price of health insurance, in turn, leads to a greater number of uninsured persons. That is because, when individuals are forced to choose between an expensive, comprehensive health plan or no coverage, many healthy, young workers opt out of the health insurance market altogether. Of course, some workers have no choice at all--they simply cannot afford to purchase health insurance coverage at current prices.

Mandated health benefits also lower wages. Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology, examined the effects of mandates for maternity care. He found that wages decreased by 5.4 percent for 20- to 40-year-old married women in states that passed mandates for maternity coverage.[52] Not only did the maternity mandates lower women's wages, the mandates also prevented individuals from buying cheaper, less comprehensive health insurance policies.

Repealing mandates without revising the tax code could benefit some, but it could leave others with restricted choices because employers will continue to choose health benefits. That is why if efforts are not made to help restore the freedom to choose health insurance through the tax system, we are likely to see a call for more mandates in the coming years. A more efficient way to restore Americans' freedom to choose the health benefits they desire is to place the decision of who buys health

insurance back in

the hands of the people. Changing the federal tax law can do that.

Restoring Health Freedom through Tax Reform

To the degree taxes are necessary, a tax system should promote economic efficiency and be perceived as fair, and it should cost as little as possible for the government to administer it and for people to comply with it. In 1994 corporate America received more than $74 billion in tax subsidies for employee health insurance, according to the most recent Congressional Budget Office study of employment-based health insurance. At the same time, federal tax law prevented any of that tax subsidy from going directly to individuals.

Worse yet, the current tax law allows employers, not consumers, to select health care benefits. As stated earlier, 48 percent of workers are offered only one health insurance plan. The one-size-fits-all tax policy forces many working Americans to accept the only health plan offered by their employer or pay higher taxes. Individuals, not employers or government, should choose something as personal as health care. That is why the current tax policy for health insurance should be reformed.

One way to reform the current tax subsidy would be to make health insurance tax deductible for all individuals. Such a policy would allow all Americans to deduct the cost of health insurance, regardless of whether it was purchased through an employer or individually. However, that policy could encourage overconsumption of medical care relative to other goods and services or savings. In particular, higher income families would be encouraged to overconsume health care because the value of the health insurance deduction rises with a family's marginal tax rate. Thus, by implementing an unlimited tax deduction for health insurance, the federal government could encourage overuse of health care services relative to other goods and services. That would further distort the health care marketplace.

Another way to remove the current distortion in the health insurance market would be to eliminate the tax subsidy for employment-based health insurance altogether. That would give consumers greater control over their health care plans. Removing the tax subsidy would raise government revenues by $74 billion ($44 billion in income tax revenues and $30 billion in Social Security payroll taxes), according to the CBO.[53] Those tax revenues could be returned to Americans by reducing the marginal

income tax rate. According to CBO estimates, eliminating the tax subsidy would reduce the income tax liability of families without employment-based health insurance but would increase payroll taxes on most families with employment-based insurance.

Those estimates do not account for the fact that, if the tax exclusion were removed, workers currently receiving employment-based health insurance could bargain with their employers for higher take-home pay. But until workers come to realize that they are receiving lower take-home pay in exchange for health benefits, it will be virtually impossible to repeal the current tax exclusion for employment-based health insurance. The majority of Americans who currently receive a tax subsidy for employer-sponsored health insurance will not be willing to give it up totally, even to help cover the uninsured.

The best way to reform the tax treatment of health insurance would be to implement a flat-rate income tax or a national sales tax. Either of those tax policies would render neutral the federal government's tax treatment of all goods and services, including health care. However, in the absence of fundamental tax reform, the most politically viable policy solution would be to implement a universal tax credit for health insurance.

A Universal Tax Credit for Health Insurance

Instead of continuing the current employer-based tax exclusion policy that limits employees' choice of health plans, the government should eliminate it and replace it with a universal tax credit. Unlike current tax exemptions, a universal tax credit would neither discriminate against those who purchased health insurance individually (by giving a preference to those who purchased insurance through employers) nor reward those who paid for health care services through insurance rather than out of pocket. A universal tax credit would render neutral the government's treatment of health insurance taxation, thus allowing individuals to purchase health insurance and health care in the way that best meets their needs.

The credit amount should be a flat amount for all taxpayers. A flat tax credit for health insurance would most benefit lower income families. Here is why: The CBO estimates that the average tax subsidy for employment-based health insurance was $690 per family in 1994. The subsidy amount ranged from $10 for lower income families to $1,390 for families earning over $200,000.[54] The universal health insurance tax credit policy would correct

that by increasing the amount of subsidy that currently goes to middle-income workers.

By capping the total amount of the tax credit, we can minimize the amount of distortion caused by granting a tax preference to health care as opposed to other goods or services. While it is important to treat all health care equally, which the tax credit does, it is also important not to dramatically expand current distortions in the system.

While the tax relief for some families will be less than that provided by the current exclusion, those families can compensate by moving to a low-cost, high-deductible policy combined with a tax-deductible MSA. High-deductible insurance plans make more economic sense in any event, because they lead to less health care consumption and lower costs.

In determining the amount of the tax credit, the first question to ask is, Should the new universal tax credit be budget neutral? Some advocates of less government would answer no. In fact, they would argue that there should be no ceiling placed on the amount of money that Americans can exclude from taxation for health insurance. But in today's political environment, where politicians are more focused on balancing the federal budget than on actually reducing the overall size of government, it would be difficult, if not impossible, to implement a tax credit policy for health insurance that costs more than today's employer-sponsored tax subsidy. For that reason, this study calls for a budget neutral universal tax credit for health insurance.

A budget neutral universal tax credit for health insurance could be implemented by distributing the current $74 billion tax subsidy equally among some 108 million families; each family would receive an average of $690 in 1994 dollars.

In designing the universal tax credit policy, four rules should be followed. First, the health insurance tax subsidy should be distributed as tax credits, not refundable vouchers. Tax credits are much more efficient than vouchers. If the tax subsidy were handed out in the form of vouchers, many Americans might come to view the voucher as a "right"--the way they view Medicare. And if health care costs continued to climb as they have during the past few decades, consumers would likely demand higher voucher amounts to offset increased health insurance costs. Credits, on the other hand, have several advantages. They make the cost of health care more obvious to taxpayers, they lead consumers to demand more for their money, and they give consumers

greater control over their health care choices. At the same time, credits reduce the amount of red tape necessary to distribute taxpayer-financed health care dollars.

Second, the tax credits should be administered by the federal treasury and should be tied to the existing tax system. Under the universal tax credit policy, all taxpayers would qualify for a credit against their annual income for all or part of the amount they spent on (1) health insurance, (2) out-of-pocket health care costs, and (3) contributions to a medical savings account for the previous year. Also, the tax credit should be made available on all federal income tax forms, including Forms E-Z and 1040A. That would give help to lower income citizens who do not typically itemize their tax deductions.[55]

Third, tax credits should go directly to individuals--not to special-interest groups such as the insurance industry--to avoid interest-group pressures. In the past, special-interest groups have heavily influenced programs that rely on the federal government for monetary disbursements. For example, industry groups such as the American Medical Association, the American Hospital Association, Blue Cross, Blue Shield, and the American Nursing Home Association designed Medicare's administrative provisions. Senior citizens had very little role, if any, in designing Medicare coverage and payment systems. It is no surprise that Medicare restricts consumer choice.

Fourth, because the government should not influence where insurance is purchased and how health care is paid for, the tax credit should cover insurance (whether employer provided or individually purchased), contributions to MSAs, and out-of-pocket health care expenses. The credit could be used to pay any health care providers or for services currently allowed as deductible expenses by the Internal Revenue Service. Those services are listed in Appendix 2.

All told, the universal tax credit for health insurance is an efficient and fair way to help Americans gain greater control over their health care choices. If individuals did not like the choice of providers and treatments covered under their employer-sponsored health insurance plans, they would be free to buy other plans without paying higher taxes. That is especially important for the 48 percent of American workers who are offered only one health plan. The universal tax credit should be considered a viable policy option for covering the uninsured while restoring health freedom for all individuals.

Conclusion

The Health Freedom of Choice Index shows that today's HMOs and fee-for-service health insurance plans restrict consumers' freedom to choose their physicians and treatments. Those restrictions are the result of federal tax law. Current tax law virtually forces Americans to purchase their health insurance through their employers, rather than individually or through private associations. Consequently, many Americans are being shepherded into HMOs. Also, consumers are turning to government mandates as a way of getting their health care needs met, which raises prices even for those who would prefer cheaper, less comprehensive plans.

The United States can help restore health freedom in the 21st century--without mandates--by changing the current tax law. The universal tax credit policy would give Americans the freedom to choose their own health insurance, whether fee-for-service plans, HMOs, or MSAs. Individuals would also be free to purchase their health insurance individually; through their employers; or through professional associations, churches, or labor unions. No existing health reform proposal or government mandate comes close to restoring that amount of freedom to health care.

Appendix 1: The Health Freedom of Choice Index

Does your health care plan allow you to choose your doctor? Are you able to select health care providers such as midwives, optometrists, or psychologists? Answer the questions below to find out how much health freedom your health care plan offers.

Circle Y for yes, N for no, or L if your choice is limited. Examples of limits include: (1) Your health plan requires you to get permission from your primary care doctor before seeing a medical specialist or other health care provider; (2) Your health plan restricts the number of days you can stay in the hospital after childbirth; and (3) Your health plan limits coverage for mental health care.

(1) My health plan covers any	10	5	0
General practitioner	Y	L	N
Medical specialist	Y	L	N
Optometrist	Y	L	N
Dentist	Y	L	N
Podiatrist	Y	L	N
Physical therapist	Y	L	N
Chiropractor	Y	L	N
Psychologist	Y	L	N
Nurse midwife	Y	L	N
Nurse practitioner	Y	L	N

Freedom to choose health care <u>providers</u> score = ____

(2) My health plan covers	10	5	0
Routine physicals	Y	L	N
Hospitalizations	Y	L	N
Eye examinations	Y	L	N
X-rays	Y	L	N
Prescription drugs	Y	L	N
Rehabilitation services	Y	L	N
Chiropractic treatments	Y	L	N
Mental health care	Y	L	N
Maternity care	Y	L	N
Home health care	Y	L	N

Freedom to choose health care <u>treatments</u> score = ____

Total health freedom score (add scores from questions 1 and 2, then divide by 2) = ____

<u>Appendix 2: Selected Deductible Medical Expenses According to Internal Revenue Code Section 213(d)</u>

Acupuncture
Alcoholism
Ambulance hire
Artificial limbs
Birth control pills
Braces
Braille
Chiropractors
Cosmetic surgery (limited)
Cost of operations
Crutches
Dental fees
Dentures
Drugs (prescribed only)
Eyeglasses, including exam
ination fee

Fees of practical nurse
Fees of healing services
Fees of Christian Science practitioners
Fees of licensed osteopaths
Health insurance (including Medicare Part B)
Hearing devices and batteries
Insulin
Laboratory fees
Laetrile by prescription
Lead base paint/removal
Nurses fees
Obstetrical expenses
Operations
Oxygen
Physician fees
Psychiatric care
Psychologist fees
Radial keratotomy
Retarded person's cost for special home
Special diets
Surgical fees
Therapy treatments
Transportation expenses
Tuition at special school for handicapped
Vitamins by prescription
Wheelchair
X-rays

Notes

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3. For a thorough discussion of how the U.S. health care market evolved from a competitive to a regulated market, see John C. Goodman and Gerald L. Musgrave, Patient Power: Solving America's Health Care Crisis (Washington: Cato Institute, 1992), pp. 137-61.

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5. Lawrence W. Reed, "Free . . . But the Patient Doesn't Get Well," in The Dangers of Socialized Medicine, ed. Jacob G. Hornberger and Richard M. Ebeling (Fairfax, Va.: Future of Freedom Foundation, 1994), p. 71.

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7. Charles E. Phelps, "The Demand for Health Insurance," in Health Economics (New York: HarperCollins, 1992), pp. 294-305.

8. John C. Goodman, "Solving the Health Care Crisis: Medical Savings Accounts," Journal of the Medical Association of Georgia 82 (June 1993): 297-300.

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11. Numerous studies show that health care consumers make cost-conscious decisions when given a financial incentive to do so. For example, the RAND Corporation conducted a study of how consumers' health care decisionmaking changes depending on the size of their copayments. The study found that an individual who had to pay 50 percent of the cost of health care spent 25 percent less than an individual with no copayment obligation. The study also showed that, contrary to the assertions of some critics, those reduced expenditures are not caused by individuals' forgoing truly necessary health care. (Health outcomes were virtually identical.) Rather, the savings result from reduced use of optional services and cost-based selection among competing providers. Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," New England Journal of Medicine 305, no. 25 (December 17, 1981): 95-112; Willard Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," American Economic Review 77 (June 1987): 251-73.

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27. H. William Scott, "Presidential Address: Professional Freedom and Governmental Control," Annals of Surgery 180, no. 4 (1974): 377-83.

28. James R. Knickman and Kenneth E. Thorpe, "Financing for Health Care," in Health Care Delivery in the United States, ed. Anthony R. Kovner (New York: Springer, 1990), pp. 240-68. See also Bureau of the Census, Statistical Abstract of the United States: 1995 (Washington: Government Printing Office, 1995), p. 119.

29. Etheredge, Jones, and Lewin, pp. 93-104.

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31. Bureau of the Census, Statistical Abstract of the United States: 1996, p. 112.

32. Pharmaceutical Research and Manufacturers of America, "Vital Statistics," Washington Post, health section, August 6, 1996.

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34. Robert E. Moffit, "FEHBP Controls Costs Again: More Lessons for Medicare Reformers," F.Y.I., Heritage Foundation, Washington, 1995. The New York Times editorial page recently reported, "The AMA's proposal [for Medicare reform] mirrors the market-based system that gives millions of federal employees a wide choice of health plans…." "The New Consensus on Medicare," New York Times, December 11, 1996. It has been noted that the FEHBP could perform the same functions that a regional health alliance would perform. President Clinton proposed that small businesses be allowed

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37. Walton Francis, Checkbook's Guide to Health Insurance Plans for Federal Employees (Washington: Washington Consumers Checkbook, 1996).

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41. Linda Ruiz, acting deputy director, Bureau of Program Operations, Health Care Financing Administration, unpublished data, April 1997.

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51. Goodman and Musgrave, p. 345, citing Gail A. Jensen and Michael A. Morrisey, "The Premium Consequences of Group Health Insurance Provisions," photocopy, September 1988.

52. Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," American Economic Review 84, no. 3 (1994): 622-41.

53. Congressional Budget Office, The Tax Treatment of Employment-Based Health Insurance (Washington: Government Printing Office, 1994), pp. i-59.

54. Ibid.

55. The credit could be made refundable. However, the author does not call for a refundable universal tax credit for health insurance. Research shows that although refundable tax credit programs such as the Earned Income Tax Credit are created with good intentions, the programs eventually lead to significant problems such as work disincentives, fraud, and a high cost to taxpayers. For a discussion of how the EITC has failed, see Michael Tanner, The End of Welfare: Fighting Poverty in the Civil Society (Washington: Cato Institute, 1996), pp. 106-9. In today's political climate it would be difficult, if not impossible, to establish a universal tax credit for health insurance without considering the need to assist low-income workers. The 105th Congress experienced that problem with their proposed child tax credit. In the end, Republicans were forced to make that credit refundable. As a result, lower income workers will receive tax refunds that exceed their payroll and income tax liability. The U.S. House Ways and Means Committee's "Summary of Revenue Provisions of H.R. 2014, The Taxpayer Relief Act of 1997," notes, "In the case of a taxpayer with three or more qualifying children, if the amount of the allowable child credit as computed under the computation described [above] exceeds the taxpayer’s regular tax liability before the computation, then the excess is a refundable tax credit." Staff of Joint Committee on Taxation, "Summary of Revenue Provisions of H.R. 2014, The Taxpayer Relief Act of 1997," 104th Cong., 2d sess., Report JCX-40-97.