

BEYOND REPEAL AND REPLACE

The Defined Contribution Route to  
Health Care Choice and Competition

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## Editor's Note

Most Americans are in government-subsidized insurance arrangements that largely insulate them from the cost of insurance and care. Open-ended federal support for health insurance coverage through Medicare, Medicaid, and the tax exclusion for employer-sponsored insurance (ESI) plans is the major reason the federal budget today is in deep deficit, and why the long-term outlook is even more daunting. Medicare's incentives for rising volume, unlimited federal funding for state-run Medicaid plans, and a tax subsidy for employer plans that grows with the expense of the plan all point in the same direction: rapidly rising health care costs.

As part of the American Enterprise Institute project, *Beyond "Repeal and Replace": Ideas for Real Health Reform*, health policy analysts James C. Capretta and Thomas P. Miller observe that the recently enacted Patient Protection and Affordable Care Act does little, if anything, to break with these longstanding policy problems. Indeed, the real point of the new health law is not to change course at all but to ensure the uninsured are also enrolled in expansive and heavily subsidized third-party insurance arrangements. The coauthors argue that a more sustainable, market-based, and patient-centered version of health reform

must instead convert existing defined benefit promises into "defined contributions" that individuals and their families then can use to enroll in coverage arrangements of their choice.

Capretta and Miller recommend that Medicare subsidies should no longer hide the true cost of promised benefits but provide beneficiaries incentives to obtain the most value for them. They find that a move to replace both traditional Medicaid assistance and the tax preference for ESI with defined contribution payments would open up new possibilities for explicit and beneficial coordination between the Medicaid program and the coverage normally offered to working-age Americans. The coauthors conclude that placing limits on what is provided through defined contribution payments, even with special provisions for additional help to low-income households, will set in motion a dynamic that will yield benefits across the entire health care system for all Americans.

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# The Defined Contribution Route to Health Care Choice and Competition

## Introduction

The principal divide in American health care policy is over what to do about rapidly rising costs. On one side are those who believe the solution is to enhance the government's power to direct resources in the health system and enforce budgetary controls. This is the point of view that animated the drafting of the recently passed health care law. On the other side are those who believe the solution is a functioning marketplace for insurance and care, not coercion and heavy-handed regulation.

The debate over which path should be taken did not end with the president's signature on the newly minted law. The Patient Protection and Affordable Care Act (PPACA) passed with support from just one of the major political parties, and it remains highly polarizing, both among elected political leaders and the public.

Building a functioning marketplace as an alternative to government control also requires changes from existing arrangements, but in a much different direction. In particular, to make a marketplace work, what we need most are cost-conscious consumers, which are sorely lacking in U.S. health care today. Most Americans are in government-subsidized insurance arrangements that largely insulate them from the cost of insurance and care. Thoughtful

pro-competition reformers have thus advanced a series of reforms that would convert those existing arrangements from open-ended benefit guarantees into what are known as "defined contribution" programs. As discussion continues of "repeal and replacement" of the new health law, we examine what exactly is meant by "defined contribution health care," as well as what is needed to ensure such a conversion would really deliver the results it promises.

## Brief Background

In the years following World War II, the United States followed much the same path as the rest of the world's advanced economies in terms of health care and old-age protection. Employers and governments at all levels erected pension and health programs that provided a guaranteed benefit to participants when certain conditions were met. To be sure, in the U.S. context, the commitments were less expansive than elsewhere, particularly in western Europe. But the basic orientation was the same. Firms and governments promised to provide retirement annuities and health benefits that were defined in law or employment contracts, without regard to whether the evolution and cost of those promises were appropriately tethered to sustainable financing arrangements.

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In the pension context, the typical form of such promises was to start paying a monthly annuity to covered workers at a certain age, based on the number of years of credited service and their highest years of wages. For health care, the promise generally came in the form of covered medical services under an insurance arrangement. The payer—in the U.S. context, often the employer but also federal and state governments—covers a large portion of medical bills filed by doctors and hospitals on behalf of enrollees in a job-based insurance plan or a government-administered health program. In most instances, those payments must be paid so long as the care rendered conforms to standard medical practice.

Over the years, these arrangements grew and expanded until the vast majority of working and middle-class Americans were enrolled in them by the mid-1960s. But things began to change in the 1970s. Large employers came under pressure from global competitors. As their workforces grew older, their related employee-pension and health-benefit obligations also grew more costly compared to others around the world. Some companies began to experiment with pension arrangements that posed less long-term risk to the sponsoring firms. Instead of promising a formulaic annuity in retirement, these firms began making fixed-dollar contributions into retirement-savings arrangements on behalf of their workers. These employers' costs were thus fixed and predictable, and the annuity a worker would get in retirement would now be financed entirely from the accumulated reserves in an individually owned account.

The growth of 401(k) arrangements thus began, and soon the trickle of firms adopting this approach became a deluge as American businesses rapidly abandoned the old model of defined benefit pension plans. In 1985, some 80 percent of all full-time U.S. workers were enrolled in defined benefit pension plans sponsored by their employers. By 2006, the number had dropped to just 20 percent.<sup>1</sup> Most of the private sector has now abandoned them, and 401(k)s, and their cousins in nonprofit and government settings, are the norm. Today, total 401(k) balances top \$2.75 trillion.<sup>2</sup> The federal government instituted such an arrangement for all its civilian workers hired after 1983, and most states have now closed off their defined benefit arrangement for state and local employees (though many still face crushing legacy burdens from overextended defined benefit plans that were never properly funded or affordable).

No such wholesale shift has yet occurred in the health care context. The vast majority of U.S. employers continue to provide to their workers enrollment in employer-sponsored health insurance (ESI) that covers necessary medical care (subject to some cost sharing by the enrollees). Similarly, the federal government's main health care programs provide coverage for medical services as specified in law.

The costs of these arrangements also continue to rise rapidly, putting enormous strain on employers, governments, and households. Indeed, the relentless, long-term increase in health insurance premiums is widely recognized as the most pressing budgetary problem for the federal government, a problem so big that it alone could push federal finances past a breaking point. American businesses and households are also under significant financial pressure as rising health premiums cut into wages and the resources available for consumption of valued goods and services.

Health care needs the same paradigm shift that has occurred in U.S. pension arrangements—a wholesale movement toward defined contribution health care, with consumers getting fixed-dollar contributions, instead of open-ended insurance promises, that they use to enroll in the health coverage arrangement of their preference. But unlike the

shift in pensions, this shift cannot start and gain momentum with private-sector firms alone. Current federal entitlement and tax policies established the rules for the entire health sector, including workers in job-based plans as well as public insurance enrollees. Those federal policies must be amended to make room for a rational rebalancing of roles and responsibilities in the financing of health care, a rebalancing that will produce systemwide benefits for all concerned.

### **The Root of Excessive Health Care Cost Escalation**

The central argument in the health care debate has been over what to do about rising costs. The prevailing view has been that the federal government's health programs experience rapidly rising costs because they are victims of the runaway cost train that is pulling the entire system down the tracks too quickly. The only way to slow the government's costs is to slow the whole train. This thinking animated many of the provisions of the new health care law.

The argument has some appeal, of course. After all, the federal government is buying services for its public insurance enrollees from more or less the same hospitals and physicians who take care of everyone else. And those hospitals and physicians are just as expensive for private payers as they are for the public ones. It would seem, then, that the problem of rapidly rising costs goes well beyond existing governmental control, and the solution is to hand over to the government even more power to control costs systemwide. Several provisions of the new health care law aim to do just that.

But this thinking misses a crucial point. Yes, one aspect of cost escalation is an exogenous factor. Rising wealth and medical discovery are fueling the demand for more and better treatments. That should not be resisted in any event. But there is widespread agreement that costs are also high and rising because of waste and inefficiency—and here the problem is not some force outside of government's control but *existing* governmental policy.

At present, most Americans get their health insurance through one of three sources: Medicare, for the elderly and disabled; Medicaid, for low-income households; and employers for the working-age population and their families. In each of these instances, the federal Treasury is underwriting rapid cost escalation because there is no limit to what Uncle Sam will pay.

In Medicare, most beneficiaries sign up with the traditional fee-for-service (FFS) insurance arrangement the program provides. It allows enrollees to see any licensed service provider, with no questions asked, so long as the patient is willing to pay the costs intended to check unnecessary use. Medicare requires substantial cost sharing—including 20 percent coinsurance to see a physician and a more than \$1,000 deductible per hospital admission—but this cost sharing is ineffective because some 90 percent of the enrollees also have supplemental coverage, in one form or another, which pays for what Medicare does not. Thus, in most instances, Medicare's beneficiaries pay nothing more when they get more care.

Congress and the program's administrators have, without interruption, tried to hold down Medicare's costs by paying less for each service provided. Those providing services to Medicare patients have responded over time by providing more services, and more intensive treatment, for the same conditions. In most cases, there is no reason for them not to provide higher-volume care. The patients generally do not pay any more when more services are rendered. And the bill is just passed on to the Medicare program—and federal taxpayers.

The result of this dynamic is hardly surprising. The volume of services paid for by Medicare has been on a steady and steep upward trajectory for decades. According to the Congressional Budget Office (CBO), the real price Medicare paid for physician fees dropped between 1997 and 2005 by nearly 5 percent, but total spending for physician services rose 35 percent because of rising use and more intensive treatment per condition.<sup>3</sup>

Medicaid fuels cost growth because it is financed with a flawed system of federal-state matching payments—with no limit on the amount that can be

drawn from the U.S. Treasury each year. For every dollar of Medicaid costs, the federal government pays, on average, 57 percent, and the states pick up the rest. But states, not the federal government, have been calling most of the spending shots in the program. The federal government has established program guidelines, but, for the most part, states determine who is eligible for what (beyond federal minimums for mandatory populations to be covered) and how much to pay hospitals and doctors for services. In this arrangement, if governors or state agents want to cut their state's Medicaid costs, they have to cut the program by \$2.30 to save \$1.00 because the other \$1.30 belongs to the federal government. Not surprisingly, most state politicians do not find that a particularly appealing option. So, instead, they spend most of their energy devising ways to "maximize" how much they get from the federal government for Medicaid services—while looking for creative ways to contribute the required state portion of the funding without really doing so.

The federal tax treatment of ESI provides a similar incentive for higher costs rather than economizing. Today, employer-paid health insurance premiums do not count as taxable compensation for workers. No matter how expensive the health insurance premium, if the employer is paying, it is tax-free to the worker. Employees thus have a strong incentive to take more and more of their compensation in the form of health coverage instead of cash wages because the health coverage is not taxable. For every dollar spent on health coverage, a worker receives a full dollar of coverage; whereas for every dollar received in other forms of compensation, a portion has to go to the government.

When you put it all together—Medicare's incentives for rising volume, unlimited federal funding for state-run Medicaid plans, and a tax subsidy for employer plans that grows with the expense of the plan—it is not surprising that health care costs are rising rapidly in the United States. The vast majority of Americans are in insurance arrangements in which a large portion of every extra dollar spent on premiums or services is paid for by Uncle Sam, not them.

And the distortions do not end there. Because of the design of these subsidy arrangements, the real

customers in our health system are not the patients but the big payers of insurance claims filed by doctors and hospitals—namely, the federal government, the states, and the country's employers. This goes a long way toward explaining the uneven quality of American health care. Especially in the employer setting, workers cannot fire their insurance company for unnecessary and repetitive paperwork, and they have little choice in deciding which doctors and hospitals are covered in their networks and which are not. Moreover, doctors and hospitals organize their operations to maximize payments from those paying the bills, not to attract patients with convenient and consumer-focused care. The result is maddening bureaucracy, paperwork, and unaccountable service delivery.

Moreover, the opaque nature of today's taxpayer-supported insurance arrangements makes it difficult to recognize who benefits the most from the current design. In particular, it is not widely understood that the tax preference for ESI provides greater value for higher-income households who are in higher-rate tax brackets than for low-wage workers who need the assistance the most to pay for health coverage. According to Congress's Joint Committee on Taxation, in 2007, the average value of the tax preference for job-based coverage was about \$2,000 for households with incomes between \$10,000 and \$30,000 per year and \$4,600 for households with incomes between \$200,000 and \$500,000 per year.<sup>4</sup> So higher-salaried workers have the strongest incentive to consume the most expensive insurance.

Federal support for health insurance coverage through the major entitlements and the tax break for job-based plans are all major reasons the federal budget today is in deep deficit, and why the long-term outlook is daunting. According to CBO, the federal government is expected to run a cumulative budget deficit of \$6.2 trillion over the coming decade, following a two-year deficit of \$2.7 trillion in 2009 and 2010. Federal debt will reach 70 percent of GDP in 2020, up from about 40 percent at the end of 2008, and that assumes all of the Bush tax cuts will expire. A more realistic scenario shows debt headed toward 100 percent of GDP.<sup>5</sup>

A major reason for all of this red ink—indeed, perhaps the most important reason—is runaway health

costs, as reflected in federal spending on Medicare and Medicaid as well as the tax break for job-based coverage. According to CBO, combined Medicare and Medicaid spending will reach \$1.5 trillion in 2020, nearly double what it was in 2009. Over the long run, CBO expects federal spending on the major health entitlements to rise from about 5.5 percent of GDP today to 10.9 percent in twenty-five years.<sup>6</sup>

### **Doubling Down on the Problem**

During the lengthy debate over the Obama administration's proposals for health care reform, the president identified systemwide, as well as federal, cost control as a key reason for moving forward on the initiative. He repeatedly promised that the reforms he was pursuing would "bend the cost curve" of health care downward so that premiums and health programs in the future would remain affordable for households, the federal government, and other payers.

This claim of slower health cost inflation stemming from the new law was always controversial, in large part because basic economic analysis indicates that a large-scale increase in the demand for health services (through new insurance coverage for millions of people) would drive costs up, not down.

But beyond this common-sense skepticism, a close examination of the new law reveals that it does little, if anything, to break with the problem causing rising costs in the first place—the federal government's open-ended subsidizing of third-party insurance for the vast majority of Americans. Indeed, the real point of the new health law is not to change course at all but to ensure the uninsured are also enrolled in expansive and heavily subsidized third-party insurance arrangements, the very arrangements at the heart of today's cost-escalation problem.

For starters, the new law puts about 16 million low-income Americans into the Medicaid program without making any structural changes in how the program operates. Even before this expansion, which primarily begins in 2014, Medicaid is in near crisis. States are buckling under the weight of its costs, even

as the networks of physicians and hospitals willing to see large numbers of Medicaid patients continue to shrink. Moreover, the distortions present in today's Medicaid matching program, which encourage high costs, will be made even worse as the new law temporarily increases the federal match for all states to 100 percent for the population of new program participants, beginning in 2014. The states will respond to this incentive quite predictably, by dropping any effort to control Medicaid's costs and by looking for ways to push even more costs off their books and onto the federal budget while they can.

### **Medicare's fee-for-service program is the primary reason American health care is fragmented, uncoordinated, and costly.**

The other major avenue for coverage expansion is through the new law's state-based insurance exchanges and federally mandated insurance regulations. By 2014, not only will all Americans be required to enroll in health insurance, they also will have to be enrolled in insurance plans that satisfy new federal rules on mandated coverage. In effect, the new law takes the concept of defined benefits health care to a whole new level by codifying in federal regulation what must be covered by nearly every insurance plan sold in the United States, and what kind of cost sharing insurers and health plan sponsors can impose on enrollees. In just a few years, modifying what is covered by insurance will no longer be a matter of contractual negotiation by supplier and consumer but of legislative and regulatory lobbying by all manner of interested parties. Inevitably, this will spawn a whole new industry of lobbyists hired to pressure the government into labeling more and more services "medical" in nature and therefore deserving of mandated coverage by all insurance plans in the country.

The new law requires almost all Americans to enroll in insurance, but this requirement survived the legislative process only because of the simultaneous extension of a massive new entitlement promise to

much of America's moderate- and low-wage households. All households above Medicaid eligibility (133 percent of the federal poverty line, or FPL) but below 400 percent of FPL will be eligible in 2014, if they are in the state-based exchange system, to have their premiums limited to a percentage of their annual income. At the low end, the cap is set at 3 percent of income and rises to 9.5 percent for those just below 400 percent of FPL (above which point those particular income-based premium limits end).

The number of American households potentially eligible for the new insurance subsidies in the exchanges is very large. According to the Census Bureau, there are about 111 million Americans under the age of sixty-five living in households with incomes between 135 percent and four times the FPL. But the CBO estimate of the final health legislation assumes only 19 million people will get subsidized insurance in the exchanges in 2019. The reason is that the law tries to erect a "firewall" around the job-based insurance system by making ineligible for the full premium assistance in the exchanges any workers who were offered qualified coverage by their employers. CBO assumes this requirement will be enough to prevent a large-scale exodus out of the employer system.

That is a dubious assumption, given the massive subsidies that workers will forgo if they are not allowed in the exchanges. According to Stephanie Rennane and C. Eugene Steuerle of the Urban Institute, a family of four with \$60,000 in income in 2016 would lose about \$3,300 in federal assistance if forced to stay in a job-based plan instead of enrolling in an exchange.<sup>7</sup>

The amounts of forgone federal subsidies are so large relative to household income that they will almost certainly lead employers to find ways to put their moderate- and low-wage workers into the exchanges instead of job-based coverage. As new businesses are formed, their managers will develop employee compensation arrangements to take maximum advantage of the open-ended federal entitlement promise. And other firms are likely to restructure their workforces as needed to ensure as many of their workers as possible are in the exchanges. If they did not, it would mean that some

workers unfortunate enough to be offered qualifying coverage on the job would get much less federal financial support than other workers with identical incomes but with access to the federal subsidies in the exchanges.

**The only way to build a network of high-quality providers is to segregate those who are providing high-quality, low-cost care from those who are not, and that is something Medicare's administrators have never been able to do.**

Former CBO director Douglas Holtz-Eakin has estimated that employers will have strong incentives to move an additional 35 million people with incomes below 250 percent of FPL into the exchanges, on top of the 19 million assumed by current CBO estimates. That level of additional migration out of employer-sponsored plans would add another \$1 trillion to the ten-year cost of the new health law, pushing the total to about \$2 trillion and precipitating massive additional federal borrowing at a time when the government is already awash in red ink.<sup>8</sup>

Once in the exchanges, many workers will have strong disincentives against seeking higher-paying jobs because, with higher wages, they will lose a substantial portion of their federal premium assistance. Combined with the extra taxes they will pay, as well as the loss of other federal support such as the Earned Income Tax Credit, food stamps, and housing vouchers, it will not be worthwhile for many low-wage workers to move up the income ladder.

The new law makes similarly problematic adjustments in Medicare that take the program backward instead of forward. Medicare's FFS program is the primary reason American health care is fragmented, uncoordinated, and costly. As volume has continued to escalate, budgetary pressure has mounted.

To control costs, many in Congress and several Medicare program administrators have talked of

converting the FFS program into a more managed arrangement in which high-quality providers would be rewarded with more Medicare patients steered to them for services. But these efforts have essentially produced no tangible results. Instead, when cost cutting became an imperative, politicians and program administrators found it far easier to hit budget targets with across-the-board payment reductions for all providers of services, without regard to measures of quality or patient satisfaction.

And, despite all the talk of “delivery system reform,” that is exactly how Medicare’s costs were cut in the new health care law. Among other things, Congress enacted a permanent “productivity improvement factor,” which will reduce the inflation increases applied to multiple Medicare payment systems. These reductions will reduce the normal update for the costs of medical practice by about half a percentage point every year in perpetuity for every provider of these services, including hospitals, without regard to how well or badly they treat patients. The compounding effect of such reductions will produce, on paper, enormous savings. But these cuts almost certainly will not be sustained as they will push Medicare payment rates for services below those of Medicaid by 2019, according to the chief actuary at the Centers for Medicare and Medicaid Services. If that actually occurred, some 15 percent of Medicare’s hospitals would stop seeing Medicare patients to avoid massive financial losses.<sup>9</sup>

The fundamental problem is that politically managed health care coverage almost always resorts to payment reductions to cut costs. That is because politicians prefer across-the-board payment cuts for everyone as opposed to picking winners and losers based on debatable quality metrics. And the only way to build a network of high-quality providers is to segregate those who are providing high-quality, low-cost care from those who are not, and that is something Medicare’s administrators have never been able to do.

The new health law further complicates Medicare’s future by compromising the one aspect of the program that has the potential to break out of this vicious cycle of rising volume and arbitrary, across-the-board payment reductions. The Medicare Advantage (MA)

program gives beneficiaries the option to take their monthly Medicare entitlement and apply it to the cost of enrolling in a private insurance plan that offers at least Medicare-covered services. Instead of using this program, which enjoys high patient satisfaction, as a platform for building a more competitive and dynamic program for the future, the new law makes deep reductions in the payments to the plans, thus downsizing the program.<sup>10</sup> The chief actuary expects that 7.2 million Medicare beneficiaries who would have been enrolled in MA plans in 2017 will be forced back into the inefficient and costly FFS program.<sup>11</sup>

Unfortunately, Medicare’s problems are not confined just to Medicare. In most markets, Medicare FFS is the largest purchaser of medical services, and the health system is organized first and foremost to maximize Medicare reimbursement. The result is a highly fragmented and disorganized medical-delivery structure, with hospitals, clinics, physicians, labs, pharmacies, hospices, and nursing homes all billing separately for services rendered for an episode of care. Pushing more beneficiaries into this system, with even deeper reductions in payments per service, will only exacerbate the already-strong incentives to make up for low payments with ever-increasing use of services.

It did not have to be this way. There are other approaches to fixing public insurance programs. Indeed, the most promising model has already been approved by Congress and implemented during the last decade. In 2003, Congress added a new prescription drug benefit to the Medicare program and built it around consumer choice, private insurance, and fixed contributions by the government. Two features of the program’s design were important to its success. First, there was no incumbent government-run option to distort the marketplace with price controls and cost shifting. All private plans were on a level playing field. They competed with each other based on their ability to get discounts from manufacturers for an array of prescription offerings that are in demand among beneficiaries and their physicians. Second, the government’s contribution is fixed and is the same regardless of what plan a beneficiary selects. The contribution is calculated based on the enrollment-weighted average

of bids by participating plans in a market area. Beneficiaries selecting more expensive plans than the average bid must pay the additional premium out of their own pockets. Those selecting less expensive plans get to keep the savings. With the incentives aligned properly, participating plans know in advance that the only way to win market share is by offering an attractive product at a competitive price because it is the beneficiaries to whom they must ultimately appeal.

This competitive structure, with a defined contribution fixed independently of the plan chosen by the beneficiary, has worked to keep cost growth much below other parts of Medicare and below expectations. At the time of enactment, there were many pronouncements that using competition, private plans, and a defined government contribution would never work because insurers would not participate, beneficiaries would be incapable of making choices, and private insurers would not be able to negotiate deeper discounts than the government could impose by fiat. All of those assumptions were proved wrong. What actually happened is that robust competition took place, scores of insurers entered the program with aggressive cost cutting and low premiums, costs were driven down, and federal spending has come in 40 percent below expectations.

But instead of building upon this successful approach to advance further Medicare reform, the new law goes in exactly the opposite direction, with heavy reliance on regulated payment reductions and government micromanagement of providers rather than strong incentives for consumers to choose high value with the limited resources at their disposal.

### **The Road Ahead: How to Move from Defined Benefits to Defined Contributions**

A more sustainable, market-based, and patient-centered version of health reform must avoid the common problems of taxpayer support of health insurance through a defined benefits structure. Those problems, whether they arise in the traditional Medicare program, state Medicaid programs, or the tax exclusion for ESI, all point in the same

direction. Taxpayer support for defined health benefits provides strong incentives for beneficiaries to spend more, not less (particularly on the margin), for health care services whose costs seemingly are paid largely with other people's money. As long as those defined health benefits are treated as open-ended legal entitlements, they will continue to place mounting pressure on federal and state government budgets.

The damaging consequences in health policy go well beyond fiscal concerns and touch the very nature and structure of health care decision making. Publicly financed defined health benefits invite third (insurers), fourth (employers), and fifth (government) parties into the patient-doctor relationship and increase their role. They confuse patients and medical providers as to who are the real buyers and sellers (or principals and agents) in medical matters and where the lines are drawn between what is determined personally and what must be handled politically. They suppress both cost sensitivity on the patient demand side and competition to deliver better value on the medical supply side.

Contrary to the initial promises often made by their advocates, taxpayer-financed defined health benefits eventually are prone to produce a host of inequities in practice. Particularly within the U.S. political culture, they have proved more likely to be regressive instead of progressive (or at least more random) in their pattern of distribution. When taxpayers' support for defined health benefits remains open ended and the ceiling on their apparent generosity is unadjusted for a beneficiary's ability and willingness to pay, the floor of public support for special treatment for the most vulnerable beneficiaries often buckles first.

A different path to health reform, as described in this study, would rely on a defined contribution structure for taxpayer support of access to necessary health services. Defined contribution payments are made more directly to beneficiaries than the various mechanisms that launder, hide, and redirect the amount and nature of defined benefit promises through other third-party intermediaries. They would empower and encourage consumers and patients to make better

health care choices. They would stimulate more innovative and accountable competition by health care providers. And they would encourage us all to save and invest so that we can pay more for health care when it delivers more value, but redirect our resources elsewhere when it delivers less.

How can we make this transition from defined health benefits to defined contributions? An integrated approach to health care financing reform would apply the defined contribution strategy to the three main insurance-coverage platforms supported by taxpayers today: Medicare, Medicaid, and ESI. Each of these platforms needs more transparent and meaningful market-based price signals on the margin. Switching taxpayer support for them to defined contributions would help make the limits of public financing more transparent, renegotiable, and more rationally allocated. No one gets 100 cents in subsidies for each dollar of health spending (even under the current system), and many do and should receive much less.

Levels of defined contribution support from taxpayers obviously should differ, depending primarily on the needs and nature of the population in question. For example, Medicaid beneficiaries have the lowest incomes and assets on which to draw to pay for their own health care. Medicare beneficiaries vary much more in income and wealth, but their advanced ages limit their opportunities to earn more and accumulate additional savings. Although their individual health status may vary across age and eligibility categories, both Medicaid and Medicare beneficiaries in general are likely to present more costly health-risk profiles and need more extensive health services. In contrast, many working-age beneficiaries of the current tax exclusion are likely to need less support, remain by definition “healthier” (they can go to work, after all), and should be more capable of independent decision making regarding health care purchasing choices. Moreover, other more refined adjustments in levels of tax support to beneficiaries within a given insurance category would remain necessary. They would be primarily based on such factors as income and health risk, but perhaps also geography.

Several basic features of defined contribution taxpayer financing would be applied in this integrated approach, regardless of whether the coverage in question was through Medicare, Medicaid, or ESI. Although defined contribution dollars from taxpayers to support such coverage would be limited, the spending of additional private dollars to enhance or expand coverage would not be restricted. Supplemental benefits (paid for with private dollars) could vary widely, beyond a baseline definition of “core” coverage (and its actuarial equivalents) that would be supported in whole or in part through taxpayers’ defined contributions. The better version of defined contribution health benefits would not just place initial control and choice of how to spend those taxpayer subsidies in the hands of beneficiaries but also provide an enhanced infrastructure of health information and connections to intermediary agents to assist them in making their choices more actionable and effective.

### **Medicare Premium Support and Competitive Bidding**

Applying a defined contribution approach to taxpayer subsidies for Medicare benefits aims primarily at encouraging private plans and the traditional FFS Medicare program to compete for market share and determine the most economical price for a given set of health care benefits for the elderly. The government contribution to beneficiaries to purchase Medicare coverage either can be determined by market means (competitive bidding) or fixed at a politically predetermined amount. Unfortunately, past attempts at more limited forms of competitive bidding for delivery of Medicare benefits have either short-circuited or tilted too heavily toward one side or the other of the public program versus private plan competition.<sup>12</sup> Neither approach thus far has informed policymakers, providers, and patients of the real cost of more efficient and effective delivery of a package of basic Medicare benefits to beneficiaries.

A more robust form of defined contribution financing for Medicare would reverse the flow of information about such costs and benefits, with

competitive bidding among health plans and providers on a level playing field telling the federal government whether its contribution levels are too high, too low, or getting closer to being about right. It is most commonly called “premium support” and was first developed in greater detail by the 1999 National Bipartisan Commission on the Future of Medicare.<sup>13</sup>

Premium support aimed at stimulating greater price competition among health plans (including traditional Medicare) and making beneficiaries more cost conscious in their choice of plans. Although its original design (which failed to receive the supermajority support from the commission required to move it ahead in Congress that year) would need to be updated, the basic elements remain worth pursuing again. They should include the following:

- Defining in broad terms the statutory health benefits package on which private plans and the traditional FFS Medicare program would bid.
- Defining the relevant market areas for competitive bidding.
- Allowing the results of the plan bids alone to determine the benchmarks for taxpayer subsidies, rather than relying on average costs for traditional FFS Medicare to determine the default settings for such benchmarks. This would increase competitive pressure on bidders to offer their best prices, rather than knowing in advance that benchmarks will be at the level of FFS costs in a given market (or close to it).
- Determining first the competitive price for core Medicare benefits in a relevant market for the average Medicare beneficiary. Then, applying other subsidy adjustments to deal with the peaks and valleys of variation in the income levels and/or health-risk profiles of particular collections of beneficiaries at the health plan level (that is, additional premium assistance for lower-income beneficiaries and risk adjustment for plans that

attract unusually large collections of high-risk or low-risk beneficiaries, whose costs of care are likely to differ substantially from average levels).

- Providing full rebates to beneficiaries choosing plans whose bids set premiums at levels below the taxpayer-subsidized level of the resulting benchmarks, but requiring them to pay the full amount out of pocket in supplemental premiums if they choose other plans whose bids (and costs) are above such benchmarks.

In the case of the Bipartisan Commission plan from over a decade ago, taxpayer support for Medicare premiums was set initially at a very generous level: roughly 88 percent of the enrollment-weighted average price of all competing bids for standard-option Medicare plans.<sup>14</sup> Of course, the actual level at which future taxpayer subsidies under premium support might increase, phase out, or be rebated to beneficiaries remains subject to rethinking and political negotiation. The most important principles include recognizing that even current Medicare subsidies are not unlimited. They should be allocated more efficiently and equitably, in a manner that no longer hides the true cost of promised benefits, while providing beneficiaries both incentives to obtain the most value for them and opportunities to enhance those subsidies with their own private resources.

A key lesson for the next round of such reform is getting the basic structure right and in place before considering further political options for possible budgetary savings. Competitive bidding processes should be aimed at discovering what it costs to deliver core Medicare benefits more efficiently and effectively. Resetting the level at which taxpayers’ funds subsidize most, but not all, of those costs is an important, but secondary, policy decision that should not be made until we know what the costs really are (or could be). It is essential that competitive bidding include the traditional Medicare FFS program as well as private plans to establish a level playing field for vigorous competition in pricing, cost transparency, and benefits design.

A basic, core benefit would be promised by statute to beneficiaries, and it would provide the “product” on which competing plans bid. This benefit package should reflect a politically acceptable quality and quantity of health care, within the resource constraints of our economy and government budgets. The core benefit cannot encompass everything that might be “desired” at a politically discounted price from the available inventory of possible health care services. A broader definition of “actuarial equivalence,” similar to the approach taken in bidding for Medicare Part D prescription drug benefits, should allow for innovation, competition, and preference-sensitive variation in what private plans offer within the core benefits packages on which they submit bids.

Although more “scoreable” budgetary savings might be achieved if the winning competitive bid is based on the lowest-cost bid made, it is much more realistic to set the competitive-bid benchmark in a given market area at the “average” cost of all bids made, with adjustment for their demonstrated ability to meet expected demand. The most practical approach is to use an enrollment-weighted average of all bids (based on the previous year’s enrollment figures for Medicare beneficiaries among the competing plans that offer bids plus Medicare FFS).

Similarly, although a long-term policy goal may be to encourage greater compression (narrowing the spread between high and low premiums) and convergence (premiums moving toward a national average and away from local market prices) of Medicare premiums and related taxpayer subsidies at the national level, early years of competitive bidding to establish premium-support subsidies should start at the more relevant level of local market-area costs.<sup>15</sup> Past efforts to artificially boost subsidies in markets where private plans struggle to build provider networks or suppress them in markets where Medicare FFS program costs are unusually high (and private-plan supply is much greater), such as in the Medicare+Choice program of the late 1990s, have misfired and reduced the overall level of public-private plan competition. Health care insurance markets and their related cost structures remain predominantly local—even for “national” programs like Medicare.

Competitive bids need to be “real.” Participating plans should be held to their bid price for core benefits package premiums until the next round of bidding begins for a subsequent “open season” for new enrollment and plan switching. Rebates for premium amounts that are below the level of taxpayer subsidies should go entirely to the benefit of beneficiaries choosing such plan options, rather than shared partially with the U.S. Treasury.<sup>16</sup> This would match the reciprocal financial disincentive to choose more costly plans, for which beneficiaries have to personally pay the full incremental amount (dollar for dollar) of any premium that is above the initial benchmark set in competitive bidding.

Real competition in Medicare plans that includes the traditional FFS program means that in some markets, private plans may not thrive. Defined contribution financing through premium support and competitive bidding cannot ensure that private plans will be abundantly available everywhere, while simultaneously rewarding efficiency with market share. Fears that FFS premiums will have to rise—or that the program’s benefits packages will need to be restructured—in markets where private plans offer more competitive premiums and better benefits really are fears that competition might work.

Ironically, both advocates of private plans and defenders of Medicare FFS often exaggerate their reciprocal worries that each type will be unable to compete successfully with the other one in most markets most of the time. However, several limiting factors in the competitive bidding process suggest that any changes in Medicare FFS and private plans’ market shares will be evolutionary rather than drastic. By making the benchmarks in local markets subject to the enrollment-weighted average of all accepted bids, the dominant market share of the longstanding incumbent, Medicare FFS, will continue to dilute the benchmark-premium effects of more aggressively low-cost private-plan bids. Nor will higher bids by private plans significantly move benchmark premiums above Medicare FFS cost levels. In other words, innovation and competition are not likely to be dramatically disruptive.

To bid and adjust to market signals in a more competitive manner, the Medicare FFS program

should be broken up into more regional administrative portions and its managers allowed discretion to act more like real health plan administrators, as recommended in the 1999 Bipartisan Commission proposal.<sup>17</sup> Congress will continue to set basic rules of the road and operating policies for Medicare FFS, but the program's administrators, in operating a public program that must become more self-funded and self-sustaining, need more leeway to respond to market signals and competitive pressures while meeting the same requirements applied to its private-plan competitors.

In paying hospitals, physicians, and others, Medicare FFS will need to move away from an approach that essentially imposes fees based on FFS's dominant role in the marketplace. That approach encourages further efforts to shift costs from the low-paying Medicare FFS to other plans. FFS's payment schedule will thus need to move closer to the genuine market prices needed to build a network of willing FFS providers and rely less on coercive price controls offered on a "take it or leave it" basis.

Special protection must be maintained for the most vulnerable low-income and/or high-risk Medicare beneficiaries. They can and should be addressed most effectively through separate policy tools: supplemental income-based subsidies and risk adjustment of aggregate premium-support payments made to competing plans.

Given the difficult political history of past efforts at demonstration projects or limited statutory exceptions to begin competitive bidding for Medicare coverage alternatives, any future premium-support reform will need to be instituted nationwide, without protecting any particular markets or competitors from more vigorous competition.<sup>18</sup>

Premium support and competitive bidding can establish a defined contribution financing platform for Medicare that will not accomplish miracles overnight but can move a number of essential health reform objectives forward:

- Establishing more predictable and sustainable patterns of public financing for Medicare benefits.

- Encouraging competition to deliver the most value for any amount of money.
- Opening up experimentation and innovation in health benefits design and health care delivery.
- Decentralizing choices and cost-benefit tradeoffs for Medicare beneficiaries.
- Beginning to unravel the brittle and always-lagging links between the administered prices and reimbursement codes of current Medicare FFS, on the one hand, and the level at which taxpayers decide to subsidize access to quality health care services for seniors, on the other hand, after becoming better informed of the full market-based costs.

### **Medicaid and Working-Age Americans and Their Families**

Medicaid was originally established to provide health coverage for welfare recipients. For those signed up for welfare support by a state, primarily under the Aid to Families with Dependent Children program, most states established automatic "categorical" eligibility for Medicaid, too.

Over the years, Medicaid has moved away from that approach. More eligibility for coverage is now based strictly on income tests. But even today, Medicaid is not integrated into the insurance system for working-age Americans. It is a separate structure with no coordination or transition between Medicaid coverage and private health insurance. This lack of coordination between the two spheres causes serious problems for Medicaid beneficiaries. When they earn more, they often lose eligibility for Medicaid, even with uncertain insurance prospects in the employer market. Thus, there is a strong disincentive to gain employment and move up the wage scale. Movement back and forth between Medicaid and private insurance plans can also disrupt ongoing relationships with physicians who are in private insurance networks but not part of a state's Medicaid plan.

A move to replace both traditional Medicaid assistance and the tax preference for ESI with defined contribution payments would open up new possibilities for explicit and beneficial coordination between the Medicaid program and the coverage normally offered to working-age Americans. For example, the financial contributions from taxpayers for health insurance coverage could be restructured so that all working-age Americans and their families receive a baseline amount of assistance equal to their proportionate share of the value of eliminating the current exclusion of employer-paid premiums from federal income and payroll taxes. In most past formulations of this proposal, a fixed, refundable tax credit would be paid to American households. That could be explicitly amended to include those who otherwise would also be eligible for Medicaid. Medicaid could then supplement this financing mechanism for those with especially low incomes who need additional support beyond the base amount (from the reallocated funds of the tax exclusion) to pay for more of their remaining premiums and cost sharing. These add-on Medicaid payments could then be phased down gradually in steps to avoid large disincentives for the beneficiaries to climb the wage and income ladder on their own.

Integration of the financing side would then allow coordination and portable insurance for low-income families who also work. One approach would be to give states an incentive to develop specific insurance-selection structures that allow Medicaid beneficiaries to enroll in the same kinds of plans as workers with higher wages. To reap the benefits of moving toward a defined contribution system, that structure should be based on full consumer choice of competing plans offering different models for accessing services. The Medicaid participants would have a greater share of their premiums subsidized by the combined tax credit and at least a substantial portion of the Medicaid payments for which they previously were eligible. But they still would face some additional costs if those beneficiaries chose to enroll in more expensive coverage options. Moreover, the plans they would select from would also be available to the working-age population.

An early model for this approach is the insurance exchange now in use in Utah. It is a facilitator of

defined contribution payments, portable insurance, and consumer choice. If other states developed a similar model and Medicaid support were also converted into a defined contribution payment for a state's nondisabled and nonelderly enrollees, those beneficiaries could be folded into the same insurance-selection model as other state residents. This would give those Medicaid beneficiaries coverage they could retain even as they moved up the wage ladder, thus avoiding disruptions in care for themselves and their spouses and children, while putting pressure on the plans to offer value and quality to keep them as paying customers.

Of course, states have been granted authority already, if they choose to exercise it, to use Medicaid funds to subsidize the purchase of private health insurance for eligible beneficiaries, such as coverage sponsored by their employer, through "premium assistance" programs. At least thirty-nine states operate some form of premium assistance through their Medicaid or Children's Health Insurance Program (CHIP). States have the option to use "wraparound" coverage that supplements an employer's health plan benefits and pays for some or all of its cost sharing, thereby delivering the same coverage as any other beneficiary in the states' traditional Medicaid programs.

However, enrollees in such options account for less than 1 percent of total Medicaid/CHIP enrollment and an even smaller portion of those two programs' spending.<sup>19</sup> Among the impediments to greater use of premium assistance are federal and state price controls that shift costs to private payers.<sup>20</sup> Premium assistance also must maneuver through complex and costly administrative procedures. Lack of affordable (or any) employer-sponsored coverage for many low-income workers, on the one hand, and employers' concern that additional enrollment will increase their own health plan costs, on the other hand, further limit the potential of premium assistance.

A different approach to Medicaid reform would rely on transferring the federal government's financial share to state governments as block grants. The main political stumbling blocks facing such grant proposals involve disagreements over how those funds would be reallocated among the states (in other words, who

wins and who loses), how generously they might be adjusted in the future relative to projected health care costs, and what level of current federal guarantees and minimum standards should be maintained. Giving state governments a different aggregate allotment of Medicaid funding and more discretion, by itself, does not necessarily solve the problems of lack of informed choice, insufficiently vigorous competition in benefits design, and poor incentives for improved health care delivery.

Proposals for “opt out” vouchers aim to encourage at least some beneficiaries to move from traditional Medicaid coverage into a choice of market-oriented private health insurance alternatives. The concept itself is attractive at the theoretical level.

The nature of Medicaid coverage as a defined benefits “welfare” entitlement tends to focus on ensuring that its rules for eligibility and benefits remain fixed, thereby leaving only its costs as the program’s primary variable. When those costs later drift upward (to meet the other two guarantees), government policymakers then are driven to try to control them through more intrusive regulation and administered prices. If financial assistance for Medicaid coverage instead were delivered to beneficiaries as a defined contribution, then taxpayer costs and program eligibility rules would be held relatively more constant, but the nature, level, and quality of Medicaid’s health benefits would become more variable. Such an approach would reward insurers, health care providers, and state policymakers for raising the quality of health care, the value of health benefits, and the satisfaction of patients, instead of just struggling to keep the apparent costs of the program lower.<sup>21</sup>

In practice, converting this idea into workable and sustainable policy reform at the state level has been an uphill battle thus far, in large part because Medicaid reform has stood in isolation from the employer market from which many Medicaid recipients bounce back and forth while periodically receiving Medicaid. In recent years, various state-level proposals for Medicaid vouchers have failed either to gain legislative approval or to build enough momentum to demonstrate clear evidence of success. Even a particularly promising blueprint for new private insurance

options in Florida’s Medicaid program has not yet reached critical mass and convinced skeptics.<sup>22</sup>

**Since its enactment in the 1960s, Medicaid has mainly been considered a health insurance program for nonworking welfare recipients and others who cannot access employer-sponsored coverage. Moving from a defined benefit to defined contribution structure allows a wholesale rethinking of the existing paradigm.**

Hence, future efforts to develop a defined contribution alternative to Medicaid’s defined benefit entitlement will need to proceed with a clear integration plan with the employer market, so that choices made by Medicaid recipients can be retained even as they move out of Medicaid financing into other coverage financed in part with tax credits. They should target initially that portion of the Medicaid beneficiary population that is below age sixty-five, nondisabled, and looking for a qualitative upgrade from coverage that promises seemingly generous benefits but pays providers too little to deliver them.

Defined contribution alternatives must be allowed to offer a different mix of benefits, cost sharing, and medical care management than traditional Medicaid. The current political climate makes the discretionary approval of Medicaid waivers for such experiments less likely and a broader legislative overhaul of the program’s financing more necessary. States pursuing more market-based, consumer-choice reforms should acknowledge that they may have to decide on a different mix of policies that include covering fewer people, leaving more details of health spending decisions to beneficiaries ready and eager to make them, paying participating health care providers for the full costs

of care, and measuring its delivered quality more accurately.

Delinking levels of state spending from federal spending on this portion of Medicaid would be equally important. The primary policy options include the politically treacherous overhaul of the Federal Matching Assistance Percentage rules that reward richer states at the expense of poorer ones and encourage additional state Medicaid spending on the margin to maximize matching federal dollars.<sup>23</sup> Rearranging the federal share of Medicaid funding into block grants to states, with future annual updates indexed somewhat below current Medicaid spending projections, provides a more formulaic shortcut. An even more aggressive approach would limit federal assistance to fully funding the upper layers of catastrophic acute care for the below-sixty-five, nondisabled portion of Medicaid, while states became responsible for financing as much of the coverage and cost sharing below those levels as they decided to handle. The latter type of reform would place much greater reliance on defined contribution assistance to Medicaid beneficiaries (through refundable tax credits) and direct contracting by state programs with competing private insurance plans.

Since its enactment in the 1960s, Medicaid has mainly been considered a health insurance program for nonworking welfare recipients and others who cannot access employer-sponsored coverage. Moving from a defined benefit to defined contribution structure allows a wholesale rethinking of the existing paradigm. With defined contributions, Medicaid could be integrated into the same private insurance marketplace populated with workers and their families, and thus allow more seamless transitions as Medicaid families move into higher-paying jobs.

### **Redefining Taxpayers' Contributions to Private Health Insurance Coverage**

For more than six decades, federal (and most state) taxpayers have subsidized ESI in a largely open-ended manner, through the so-called “tax exclusion.” The tax preference for job-based plans—which began with an Internal Revenue Service (IRS) ruling in 1943

and was codified more formally when Congress enacted the Internal Revenue Code of 1954—excludes the value of group health insurance paid by an employer from the income and payroll taxes of employees who receive it as a work-related benefit.<sup>24</sup> Although the tax exclusion has contributed in part to the growth of more comprehensive levels of private health insurance coverage, it also has:

- raised the overall cost of health insurance and health care;
- favored health spending over other types of consumption and investment;
- reduced transparency in health care pricing;
- dampened cost consciousness by insured workers;
- increased third-party control of health care decisions;
- skewed the distribution of tax benefits to higher-income workers;
- disadvantaged individual (non-ESI) purchasers of health care; and
- produced disruptions in insurance coverage for workers changing (or losing) jobs.

At the core of the above criticisms of the tax exclusion is its open-ended, uncapped nature as a “defined benefit entitlement” of the tax code, along with its selective favoring of certain purchasers of health insurance (higher-income workers in larger firms offering comprehensive insurance) over other ones.

The new health law took the first limited step toward revising the tax treatment of job-based health insurance in more than six decades, by adopting a so-called Cadillac tax on more costly employer-provided health benefits plans. Its primary rationale was to demonstrate commitment to slowing the future growth rate for health insurance premiums and the health care they finance. However, its “cap” on the projected level of tax expenditures also provided revenue offsets for other new health insurance subsidies under the PPACA.

The effects of the Cadillac tax were delayed until 2018. The thresholds at which it would first apply were set at relatively high levels (the amount of employer-sponsored premiums above \$10,200 for individual coverage and \$27,500 for family coverage), although they were indexed to become more binding in later years. Special adjustments and exceptions were made for the age and gender composition of an employer's payroll, as well as for certain retirees and individuals working in high-risk professions. However, critics pointed out that the remaining "nominal" cost of high-premium plans to which the Cadillac tax would apply still failed to reflect whether their coverage was unusually comprehensive (in other words, their real "actuarial value"). Other factors such as firm size, the health status and average age of its employees, and geographic location also can affect the "cost" of health coverage.<sup>25</sup>

The Cadillac tax was structured differently from earlier proposals to cap the value of the tax exclusion for individual workers covered by ESI. To maintain the illusion that only insurers and employers would pay this new tax on high-cost insurance plans, it was imposed as a 40 percent excise tax on the "issuers of the insurance" (insurers for fully insured plans; either third-party benefits administrators or employers for self-insured plans). The costs of this tax—applied to the amount by which an employer plan's premiums exceeded the thresholds—will ultimately be passed on to insured employees. However, the Cadillac tax's design will create several distortions in its incentives by disconnecting its uniform "wholesale" rate from those workers' different marginal income tax rates at the "retail" level. Either the parties who appeared to pay the tax (insurers, administrators, self-insured employers) would be different from those workers who need more direct and transparent incentives to demand (or select) less expensive health benefits,<sup>26</sup> or the latter might face taxes on their benefits at rates much greater than those applying to their wage income.

Skeptics also question whether the Cadillac tax of the future will ever actually be imposed. Aside from political opposition from those employer and employee groups that are its most likely targets, it also

would squeeze employer-plan sponsors between a rock and a hard place. At the same time that the nontaxable ceiling for an employer plan's average premium grew below the rate of health cost inflation over time, other provisions of the PPACA would set a floor for increasingly expensive "essential benefits" coverage.<sup>27</sup> At some point, the floor below which employer-sponsored plans must not fall would bump into the ceiling above which those plans get taxed. Moreover, the Cadillac tax deals only with employer-provided group insurance, while failing to provide more balanced tax treatment of other kinds of health insurance purchased by individuals outside their workplace.

The political and economic complications of the Cadillac tax largely reflect the tradeoffs of tax policy for health care and the shortcomings of relying on a single policy instrument (tax subsidies for health spending and/or health insurance) to accomplish at least a half dozen or more different goals. In considering alternative reforms for the tax treatment of health care, one can more easily do one thing well than too many things at once less effectively and at cross purposes with each other.

For example, if the policy goal is to reduce the regressive rates at which tax subsidies for health insurance are distributed under the mirror image of a progressive income tax rate structure, one could instead provide the same proportional tax "discount" for everyone with fixed-percentage tax credits applied to health insurance premiums at any level. The most likely median percentage would be around 30 percent (a combination of the total employer/employee Federal Insurance Contributions Act (FICA) tax rate of 15.3 percent plus the most common federal income tax marginal rate of 15 percent). This approach might be fairer and more evenhanded for most purchasers. Its level of tax subsidies would adjust automatically for premiums that vary based on a purchaser's geography or health-risk factors. But it would sacrifice cost-containment incentives as "uncapped" tax expenditures.

If policymakers instead wanted to focus on providing more financial assistance directly to low-income purchasers of health care, the more effective approach would be to provide them with more

generously funded vouchers or health spending certificates (or even less restricted general income support), rather than spread taxpayer subsidies more widely and thinly. However, using dedicated appropriations that are distributed outside the tax code to do so is handicapped by the lack a database for taxable-income information and a broad-based subsidy-delivery system. Only the IRS has the data to match one's taxable income to the dispensing of income-related subsidies.<sup>28</sup> Subsidies through the tax code also generally carry less regulatory baggage and conditionality than cash-equivalent vouchers tied to the appropriated budgets of executive-branch departments and agencies.

**The political and economic complications of the Cadillac tax largely reflect the tradeoffs of tax policy for health care and the shortcomings of relying on a single policy instrument to accomplish at least a half dozen or more different goals.**

On the one hand, if the most important health policy goal is to eliminate the inefficiencies and distortions in health spending created by the current tax exclusion, *without raising overall federal income taxes*, the better approach would be to completely eliminate the tax exclusion but reduce marginal income tax rates across the board by an equivalent offsetting percentage.<sup>29</sup> On the other hand, if policymakers simply want to provide new tax subsidies to lower-income people without reducing current tax subsidies for anyone else, they could consider a hybrid approach in which refundable, fixed-dollar credits were offered to health insurance purchasers below a particular level of income, while other workers receiving job-based insurance could choose to retain the benefits of the current tax exclusion.<sup>30</sup> Of course, while this approach would offer something to everyone buying health insurance, it also would substantially increase

the level of tax expenditures for health care in the federal budget and fail to address most of the inefficiencies and distortions of the current tax exclusion.

More narrow health policy goals could be achieved through targeted tax reforms. For example, alternative insurance-pooling mechanisms could be strengthened by linking tax subsidies either exclusively or more generously to pools with better rules for multiple insurance options, coverage portability, and long-term protection against changes in one's health status.<sup>31</sup> Or if policymakers favored more growth of catastrophic-level insurance with less early-dollar coverage of discretionary health spending, they could tie tax subsidies to plans offering major-risk insurance protection with an income-related stop loss.<sup>32</sup>

The point of the above menu of tax policy options for health care is not to suggest any one of them above all others, but to demonstrate how trying to do too much, or too little, can hamper the achievement of a more workable balance.

The defined contribution approach to reforming the tax treatment of health insurance would focus on restoring a more level playing field for all purchasers. Extending income tax deductibility alone falls short in its scope, unless the exclusion of taxes on insurance premium payments is extended to FICA payroll taxes as well.<sup>33</sup> However, that tax policy approach also fails to deal with income distributional effects of such tax subsidies under a progressive rate structure. Hence, the general starting place for more balanced, defined contribution tax subsidies involves flatter, fixed-dollar refundable tax credits.<sup>34</sup> They better maintain neutral incentives on the margin for health spending at higher amounts than the fixed credits subsidize.

In a real sense, moving toward a universal, fixed-dollar tax credit would represent a "universal coverage" alternative to the new health law's menu of mandates, heavy regulation, and government coercion. Conversion of today's tax preference for employer-paid premiums into a refundable, universal credit for the under-sixty-five population would mean that every American household—whether working or not—would have access to a tax credit that could only be used for the purchase of health insurance. The value of the credit might

approximate the current average tax subsidy for job-based coverage—in the range of about \$5,000 to \$6,000 per family.<sup>35</sup> Any household that chose to forgo insurance would lose the entire value of the credit. It is far more likely that most households would use the credit to get the best coverage available to meet their needs, given the size of the credit and whatever additional resources they would be willing to provide for coverage. And there would undoubtedly be a large supply response from insurers, offering all manner of options to meet the needs of millions of cost-conscious consumers.

Critics sometimes argue that the value of the credit is too small to be attractive, given that average premiums today for employer-sponsored family coverage exceed \$13,000 annually. But the truth is that the tax preference for such coverage will only be valued at about 40 percent of the total premium for most middle-class families. Even if the employer pays the full premium, most if not all of that “contribution” is effectively coming out of the worker’s total compensation, and his otherwise-higher cash wages.<sup>36</sup> Consequently, the move toward a fixed tax credit need not result in any loss of total income for most households. In competitive labor markets, firms will substitute cash wages for what they previously spent on employer-paid health care premiums to retain their workers. Workers will be able to use those higher wages, plus the tax credit, to purchase coverage at least as comprehensive as they have today. Of course, they will also have the option of buying less expansive and expensive coverage, and perhaps increasing their consumption of other goods and services or even just saving the difference for future needs.

In their pure form, fixed-dollar tax credits necessarily fail to adjust to a beneficiary’s health-risk status or income level. The ultimate policy tradeoff here involves the feasibility of making such fine-tuned adjustments, and the administrative ability to do so, given the current informational and temporal limits of risk adjustment and income reporting. Further improvements in deploying real-time health information technology and enhanced electronic health records would allow the tax-credit route to defined

contribution subsidies for private health insurance to advance faster, further, and more fairly.<sup>37</sup>

**Moving toward a universal, fixed-dollar tax credit would represent a “universal coverage” alternative to the new health law’s menu of mandates, heavy regulation, and government coercion.**

Today, there are about 170 million Americans in tax-subsidized, job-based plans. For the most part, they are passive enrollees in insurance plans chosen by their corporate human resource departments or their small-firm employers. The challenge for policymakers is balancing the desire to unleash the potential of introducing millions of new cost-conscious consumers to a more competitive insurance marketplace with concerns that this policy change might lead to undue disruption of current coverage and insufficient capacity to provide viable choices and options. Nonetheless, it remains true that it will not be possible to build a competitive health system without beginning that process, sooner rather than later.

### **The Ryan Roadmap and Productivity in the Health Sector**

Many analysts favoring a move to a market-based health system have discussed the need to restructure health entitlements and tax policy. But only one current plan has been introduced to do exactly that across the board: the “Roadmap” offered by Representative Paul Ryan (R-Wis.).

In putting together the Roadmap, Ryan’s explicit objective was to restore long-term balance to the government’s budget without resorting to an antigrowth tax hike. The incoming chairman of the House Budget Committee wants to build an affordable network of entitlement programs that will not crush entrepreneurial initiative and dynamism.<sup>38</sup>

The most important ingredient in achieving that objective is the move toward defined contribution health care, across the board. The Roadmap simultaneously restructures Medicare, Medicaid, and the tax preference for employer-paid insurance. The plan clearly highlights this as a crucial step both for improved health care and for restoration of long-term balance to the federal budget.

In the Roadmap, Americans age fifty-five and younger would enter into a restructured Medicare program that paid fixed-dollar amounts to the cost of their health insurance. The tax exclusion for employer health care would be repealed and converted into fixed-dollar refundable tax credits for all households with someone under the age of sixty-five.<sup>39</sup> And states would choose either to allow their Medicaid recipients (except those who are disabled or receiving long-term care assistance) to participate in the tax credit plan (augmented by additional generous low-income assistance) or to use federal block-grant funding to restructure their Medicaid programs with greater flexibility.

These reforms are central to achieving Ryan's budget objectives, as CBO confirmed in its initial cost estimates of the plan. Over the long run, the massive run-up in debt that would occur under current law would be avoided entirely, even as taxes remained at the historical percentage of the nation's economic output.

But even these numbers do not fully capture the importance of what Ryan has proposed. Yes, it would establish far better budgetary control, but the Roadmap approach would also help establish a much more dynamic and productive health sector. The Ryan plan would convert tens of millions of passive insurance enrollees into cost-conscious consumers. The combined effect of doing so across age groups and health care arrangements would create tremendous competitive pressure on the entire health sector of health insurers and health care providers to deliver much higher value for the dollars spent. Any health sector player that did not step up and improve its productivity would risk losing substantial market share among seniors, working people, and those on Medicaid.

The Ryan Roadmap is thus not just a budget plan. It is also a plan to transform American health care. It is built on the fundamental principle that a consumer-driven system, with appropriate government oversight, can deliver much better health at lower costs than we are getting today.

### Conclusion

It is understandable that as social welfare benefits were extended in the post-World War II era, governments and businesses sought to provide workers, their families, and other citizens assurances of what they could expect in terms of retirement and health benefits. The sponsors of those plans took on the risk of financing a guaranteed package of benefits, thus providing a level of certainty and security that workers found attractive.

But that model contains its own, more subtle kind of risk. With workers insulated from risk and costs, incentives become skewed. There is less reason to extend one's working years further if it makes no difference in the future amount of income and retirement benefits. And in the health sector, fully insulating consumers from costs undermines the proper functioning of the marketplace, leading to cost distortions and poor accountability.

Ironically, the solution to the challenges we face, especially in public policy for health care, is for the federal government to do less, not more, but also to do that more intelligently and with more focus. The government can and should still provide substantial financial support for adequate health care provision. But placing limits on what is provided through defined contribution payments, even with special provisions for additional help to low-income households, will set in motion a dynamic that will yield benefits across the entire health care system for all Americans. The result will be less fiscal stress, a healthier population, and a health care sector that is more productive and innovative than ever before.



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12. Early versions of private-plan competition in Medicare began with reimbursements for those plans set at a lower percentage (95 percent) of adjusted local market-area costs for Medicare FFS. The next approach, in the Medicare+Choice program of the late 1990s, tried to compress variation in private-plan reimbursements by raising payments in "floor" counties with lower FFS costs and lowering them in counties with higher FFS costs and (not surprisingly) greater participation by private plans. Other efforts over the last two decades to launch competitive-bidding demonstration projects less tied to local FFS costs were stymied by legal challenges and political opposition. The Medicare Modernization Act tried another approach by first raising benchmarks for private-plan bids to levels somewhat above those of FFS costs and then requiring plans to "rebate" resulting higher payments to beneficiaries in the form of enhanced benefits and/or lower cost sharing. For further background, see Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs* 19, no. 5 (2000): 9–29, available at <http://content.healthaffairs.org/cgi/reprint/19/5/9.pdf> (accessed November 23, 2010); Medicare Payment Advisory Commission (MedPAC), "Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending," Medicarebriefs, June 9, 2006; and Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare: Essential Reform at a Time of Fiscal Crisis*

(Washington, DC: AEI Press, November 2009), available at [www.aei.org/book/100030](http://www.aei.org/book/100030).

13. National Bipartisan Commission on the Future of Medicare, “Building a Better Medicare for Today and Tomorrow,” March 16, 1999, available at <http://thomas.loc.gov/medicare/bbmtt31599.html> (accessed November 23, 2010).

14. *Ibid.* As proposed to the commission by its chairman, Senator John Breaux, in January 1999, the premium-support payment formula provided that, on average, beneficiaries would be expected to pay 12 percent of the total cost of standard-option plans. For plans that cost at or less than 85 percent of the national weighted average, there would be no beneficiary premium. For plans with prices above the national weighted average, beneficiaries’ premiums would include all costs above that amount. Another formula for additional partial taxpayer subsidies would have applied to premium bids between those two levels (20 percent of the amount above 85 percent, but at or below 100 percent, of the national weighted average).

15. Although the long-term policy goal may be for the regional and local market differences in Medicare plan premiums to become less significant over time, as they move closer to the level of a national average premium, the current market reality is that health care remains shaped by geographically different costs and prices. Hence, it is more practical to begin any competitive bidding process at the level of counties (similar to Medicare FFS cost data) or metropolitan statistical areas, and probably not even at the entire state level. Bidding areas might move toward more regional market areas over time.

16. Until passage of the PPACA, Medicare Advantage private plans that bid below the “benchmark” for their market area also received payment from Medicare in the form of a “rebate.” This rebate amounted to 75 percent of the difference between the plan’s actual bid and its casemix-adjusted benchmark. The plan then had to return the rebate to its enrollees in the form of either supplemental benefits or lower premiums or other reduced cost sharing. In other words, Medicare “kept” 25 percent of the amount by which plans bid below their benchmarks. However, the PPACA not only lowers future benchmark levels for private plans, but also reduces the rebate share that those plans, and their enrollees, are permitted to keep when their bids are below the benchmark (from 75 percent to 50 percent for plans receiving three or fewer “quality” stars out of five), with changes fully phased in by 2014. Plans with high quality ratings will receive larger rebates, if their bids are below the benchmark. See Henry J. Kaiser Family Foundation, “Medicare Advantage Fact Sheet,” September 2010, available at [www.kff.org/medicare/upload/2052-14.pdf](http://www.kff.org/medicare/upload/2052-14.pdf) (accessed November 26, 2010).

17. National Bipartisan Commission on the Future of Medicare, “Building a Better Medicare for Today and Tomorrow.”

18. See Bryan Dowd, Robert Coulam, and Roger Feldman, “A Tale of Four Cities: Medicare Reform and Competitive Pricing”; and Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare: Essential Reform at a Time of Fiscal Crisis*.

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22. See, for example, Michael Bond, “Reforming Medicaid in Florida,” James Madison Institute, Backgrounder No. 65, April 2010, available at [www.jamesmadison.org/wp-content/uploads/pdf/materials/Bkgrnder\\_ReformMedicaid\\_BondApril10.pdf](http://www.jamesmadison.org/wp-content/uploads/pdf/materials/Bkgrnder_ReformMedicaid_BondApril10.pdf) (accessed November 23, 2010); Joan Alker, Jack Hoadley, and Jennifer Thompson, “Florida’s Experience with Medicaid Reform: What Has Been Learned in the First Two Years” (Washington, DC: Georgetown University, Health Policy Institute, October 2008), available at <http://hpi.georgetown.edu/floridamedicaid/pdfs/briefing7.pdf> (accessed November 23, 2010); and Agency for Health Care Administration, “Florida Medicaid: Year 4 Draft Annual Report (2010),” available at [http://ahca.myflorida.com/medicaid/medicaid\\_reform/pdf/reform\\_draft\\_annual\\_report\\_yr4\\_070109-063010.pdf](http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/reform_draft_annual_report_yr4_070109-063010.pdf) (accessed November 24, 2010).

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27. Robert H. Dobson, “No Room to Stand,” Milliman Health Reform Briefing Paper, September 2009, available at <http://publications.milliman.com/research/health-rr/pdfs/no-room-to-stand.pdf> (accessed November 23, 2010).

28. See, for example, Fred T. Goldberg Jr. and Susannah Camic, “Legal Solutions in Health Reform: Tax Credits for Health Insurance,” Linda D. and Timothy J. O’Neill Institute for National and Global Health Law at Georgetown Law, 2009, available at [www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Papers/Tax.pdf](http://www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Papers/Tax.pdf) (accessed November 24, 2010).

29. For an example of one such approach, see President’s Advisory Panel on Federal Tax Reform, “Simple, Fair, and Pro-Growth: Proposals to Fix America’s Tax System,” November 2005, available at <http://govinfo.library.unt.edu/taxreformpanel/final-report/index.html> (accessed November 23, 2010).

30. Various proposals to do this include the *Empowering Patients First Act*, HR 3400, 111th Cong., 1st sess. (July 30, 2009), available at [http://rsc.tomprice.house.gov/UploadedFiles/HR\\_3400\\_EPFA.pdf](http://rsc.tomprice.house.gov/UploadedFiles/HR_3400_EPFA.pdf) (accessed November 24, 2010), introduced by Representative Tom Price (R-Ga.); *Patient Access, Choice, and Equity Act of 2000*, HR 4925, 106th Cong., 2d sess. (July 24, 2000), available at [www.govtrack.us/congress/bill.xpd?bill=h106-4925](http://www.govtrack.us/congress/bill.xpd?bill=h106-4925) (accessed November 23, 2010), introduced by Representative John Cooksey (R-La.); and Thomas P. Miller, “Improving Access to Health Care without Comprehensive Health Insurance Coverage: Incentives, Competition, Choice, and Priorities,” in *Covering America: Real Remedies for the Uninsured*, vol. 2 (Washington, DC: Economic and Social Research Institute, 2002).

31. *Ibid.*

32. Martin Feldstein and Jonathan Gruber, “A Major Risk Approach to Health Insurance Reform” (Working Paper 4852, National Bureau of Economic Research, Cambridge, MA, August 1997), available at [www.nber.org/papers/w4852](http://www.nber.org/papers/w4852) (accessed November 23, 2010).

33. A temporary provision to do this in part for the rest of 2010 can be found in a recent amendment to section 162(l) of the Internal Revenue Code by the *Small Business Jobs and Credit Act of 2010*, Public Law 240, 111th Cong., 2d sess. (September 27, 2010); Section 162(1) is available at [www.taxalmanac.org/index.php/Sec.\\_162](http://www.taxalmanac.org/index.php/Sec._162) (accessed October 1, 2010).

34. Coauthor Miller has previously proposed a different “back to the future” mix of tax-subsidy features for health care spending that might come closer to achieving a number of the aforementioned health policy objectives in a comprehensive manner. One might consider how tax policy for health care could work within the basic structure of how the federal tax code treated health expenses in 1942, the year before the tax exclusion for employer-paid health insurance was first authorized. The Revenue Act of 1942 allowed taxpayers to deduct expenses for unusual medical expenses, in excess of 5 percent of their net (adjusted gross) income. It also capped that deduction so it could not exceed \$2,500. Five changes to that older, basic structure might provide more sustainable equity and efficiency in health care today, as one alternative. They include the following:

- Change that itemized deduction to an above-the-line fixed-percentage tax credit (perhaps 25 percent or 30 percent);
- Apply it against both insured and uninsured health expenses;
- Make it refundable (for those who earn income but do not pay federal income taxes);
- Lower the initial threshold for tax subsidies (perhaps to health spending above 3 percent of adjusted gross income) to maintain initial cost consciousness for more discretionary and manageable items, but adjust it in proportion to income;
- Set the maximum tax-subsidy cap somewhat above the average cost of today’s private health insurance policies, but then index it to general rather than medical inflation.

And just one more thing: phase out all other personal tax subsidies for health spending and allow health consumers, and their chosen agents, to decide how to sort out the rest.

35. Of course, if policymakers insist on budget neutrality under the current law baseline, that amount of average tax subsidy spread across a broader population would need to be lower. If increasing assistance to lower-income Americans and those previously not benefitting from the current tax exclusion becomes a more important policy goal than budget neutrality, the “new” amount of this average tax subsidy could be higher.

36. Michael A. Morrissey, “Why Do Employers Do What They Do? Compensating Differentials,” *International Journal of Health Care Finance and Economics* 1, no. 3–4 (1995): 195–201, available with subscription at [www.springerlink.com/content/q6104703146k521v](http://www.springerlink.com/content/q6104703146k521v) (accessed November 23, 2010); and Mark V. Pauly, *Health Benefits at Work: An*

*Economic and Political Analysis of Employment-Based Health Insurance* (Ann Arbor: University of Michigan Press, 1997).

37. For example, see Stephen T. Parente, “Harnessing Health Information in Real Time: Back to the Future for a More Practical and Effective Infrastructure” (Washington, DC: AEI, December 2010).

38. Representative Paul D. Ryan, “A Roadmap for America’s Future: Version 2.0,” Committee on the Budget,

U.S. House of Representatives, January 2010, available at [www.roadmap.republicans.budget.house.gov/UploadedFiles/Roadmap2Final2.pdf](http://www.roadmap.republicans.budget.house.gov/UploadedFiles/Roadmap2Final2.pdf) (accessed November 24, 2010).

39. The tax credits for individuals and their families would be risk adjusted and income related, however, and their value would be indexed to a blend of future general price inflation and medical price inflation.