Effective Healthcare Reform Starts With a Tax Fix

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Healthcare reform is moving back onto center stage, and mostly for good reasons. While the U.S. system can, under the right circumstances, deliver the finest care in the world, rising costs, unstable insurance arrangements, burdensome paperwork, and bureaucratic processes have left virtually no one happy with the status quo. It is particularly troublesome to many that nearly 9 million children lack stable insurance coverage. Experts from across the political spectrum believe reform is necessary to provide stronger incentives for cost control, stabilized and expanded insurance coverage for children and their families, and improvements in quality of care across the board.

Two of the most innovative healthcare reform initiatives in a decade seek to address many of those flaws, starting, perhaps counterintuitively, with tax policy. Many Americans might wonder, ''What do taxes have to do with healthcare?'' Everything, it turns out. Federal tax policy is the most important reason we have an employer-based health insurance system, for good and ill, and addressing the system's shortcomings cannot be done well without reworking — or, as Massachusetts has done, working around — the federal tax laws that have led to today's system in the first place.

Federal tax policy became intertwined with health policy by historical accident. During World War II, some employers began offering health benefits to increase employees' compensation without running afoul of wartime wage controls. Soon after, the IRS ruled that such arrangements were excluded from federal income and payroll taxes. With that strong financial push, virtually all employers of any real size were soon offering health coverage to compete for the best workers.

Today, employer-based coverage dominates the U.S. system of private health insurance. According to Census Bureau data, in 2005 more than 160 million Americans under age 65 had employer-sponsored insurance, or nearly two-thirds of the entire population under age 65. Only 17 million Americans under age 65 had individually purchased insurance coverage.

The employer-based system has some advantages. Workplaces are convenient settings for risk pooling, as employers generally do not hire based on health status. Consequently, one would expect large employers to have a reasonable mix of good and bad health risks. Large employers also can keep administrative costs low, particularly compared with individually purchased insurance.

But there are serious problems with overreliance on such a system, too. The tax-exempt status of job-based insurance has provided a strong incentive to forgo cash wages in favor or expansive health coverage. With low-deductible insurance, consumers have little knowledge or understanding about the cost of care they seek, as their insurance plans process and pay nearly all of their bills. Many health economists point to the open-ended nature of the current federal tax exclusion — which subsidizes premium payments but not out-of-pocket costs — as a primary cause of rapid healthcare cost inflation.

Employment-based insurance is also not portable; every time a worker switches jobs, he must switch insurance plans too (the average American will hold more than 10 different jobs between the ages of 18 and 40). But what if someone is between jobs? Or a seasonal worker? Or an early retiree? Attaching tax-favored status exclusively to group-rated insurance offered at the workplace makes it nearly impossible for stable nonemployer groups to form. The inevitable result is frequent gaps in coverage for those on the margins of the job market. In short, employment-based insurance is stable and works well for employees in large firms and for their families, but it is quite unstable for everyone else.

The Census Bureau estimates that there were 45 million people without health insurance in 2005, but that estimate does not fully reflect who is permanently without insurance coverage and who is experiencing a temporary gap in coverage. To provide a more complete picture, researchers Pamela Farley Short and Deborah R. Graefe tracked insurance coverage for a representative sample of the U.S. population for a four-year period. They found that nearly 85 million people went at least one month without insurance coverage during that span. However, only 10 million of those people were uninsured for all four years covered by the researchers', and about half of the people were uninsured for less than a year. Their findings make it clear that many millions of Americans move frequently between having and not having insurance. Indeed, some 28 million of those who experienced at least one month without coverage actually had two or more spells of being both insured and uninsured during the four-year period covered by the study.

Reducing the ranks of the uninsured within a private insurance system will require finding a way to allow

people who are not attached to a large employer to keep their insurance even as they switch jobs or leave the workforce. But how?

One approach would be to change federal tax law to level the insurance playing field, so to speak, which is what President Bush has proposed. Bush's proposal would replace today's exclusion of employer-paid premiums from income and payroll taxes with a new, but limited, standard deduction for insurance that would accrue to job-based as well as individually purchased coverage. Passage of that proposal would make the individual market for insurance much more attractive than it is today, because premiums for such policies would be treated identically to employer-paid premiums. Establishing a fixed amount for the deduction — $15,000 for families and $7,500 for individuals — would also provide strong incentives to secure lower-cost coverage.

Indeed, the standard deduction threshold in Bush's plan may be too constraining for family insurance plans. According to the Kaiser/Health Resources and Education Trust, the average premium for employer-based family coverage is 2.7 times the premium for the average policy covering a single person. Adoption of the president's $15,000/$7,500 thresholds would thus likely induce the breakup of many family insurance arrangements, with spouses enrolling in separate coverage and parents enrolling children in public insurance to avoid paying premiums above the $15,000 standard deductible. To keep parents and children enrolled in the same insurance plan, the standard deduction thresholds should more closely reflect today's marketplace, which would imply a deduction of about $20,000 for health insurance covering a whole family in 2009.

Critics of the president's plan have also charged that it would lead to a stampede out of employer groups and into an ill-prepared individual marketplace. The shift is more likely to be gradual than abrupt, however, as large employer plans will remain attractive because of their lower administrative costs. Nonetheless, it would be better to combine effective federal tax reform with creation of new arrangements for securing stable, nonemployer group-rated insurance. Here, Massachusetts's new ''Connector'' can serve as an important model — even without a change in federal tax law.

The Connector is the new state agency charged with providing private insurance options for eligible enrollees under Massachusetts's universal coverage plan. Connector-eligible residents are employees of firms with 50 or fewer workers and other individuals ineligible for large employer coverage. One of Massachusetts's real innovations is the creative extension of favorable federal tax treatment to the Connector's insurance offerings, even as individuals, not firms, select and purchase the insurance. Small businesses are not required to join the Connector, but most firms are likely to join to avoid the difficult and time-consuming process of finding affordable coverage on their own. To join the Connector, though, small employers must agree to establish tax-favored section 125 plans for all of their eligible employees, which will allow those workers to pay their health insurance premiums with the same substantial tax advantage granted to employer-paid premiums today. Indeed, for many workers, the value of this federal tax subsidy will be about one-third the cost of an insurance plan.

The Connector also provides a ready administrative structure for administering direct, state-funded premium subsidies. Beginning July 1 of this year, families with incomes under 300 percent of poverty who get their coverage through the Connector will get premium vouchers, funded in part through redirection of existing payments to hospitals for uncompensated care. Eligible families will be able to use the vouchers to offset some of the cost of the insurance plan they select.

Massachusetts's approach is not perfect. Plan premiums remain too expensive, in part because of the state's heavy regulatory structure. Over time, sensible regulatory relief and a stronger competitive environment among the Connector's offerings may help to slow cost growth. Also, low-income families who get their insurance through large employers are not eligible for the premium subsidies. Thus, two families with identical financial profiles can be treated very differently. In addition to raising equity concerns, that structure is likely to induce a migration of low-income families into the Connector, with some large employers encouraging the migration to lessen their own costs.

And yet, despite those flaws, Massachusetts has blazed a promising trail, starting with its creative use of existing federal tax law, which will facilitate individually owned and more portable insurance for many state residents. In addition to broadening and stabilizing insurance coverage, the Connector's reliance on consumer choice, as well as on price and quality competition among insurers, should promote more efficient health-care delivery, better service, and higher-quality care.

Congress would be wise to encourage other states to follow Massachusetts's lead, and reauthorization of the State Children's Health Insurance Program (SCHIP) provides an ideal opportunity to do so. Children are uninsured for essentially the same reasons their parents are uninsured, with gaps in coverage caused substantially by their parents' inconsistent attachment to stable, employer-based plans. An effective SCHIP law would push states to use whatever additional federal funds are provided (Congress is considering a $50 billion funding increase over five years) to build reliable, nonemployer group insurance mechanisms — in other words, more Connectors. Those arrangements can provide the insurance portability necessary to eliminate gaps and stabilize coverage for parents and their children.

Some worry that private health insurance coverage is often not designed with children in mind, making it ill-suited for a public effort concerned with ensuring quality care. But states would almost surely oversee the benefit packages provided by the insurers, which should prevent unwise benefit designs. Moreover, SCHIP funds could be used to pay for important wraparound coverage if it was found to be necessary to ensure appropriate use, particularly of preventive services.

An important advantage of state-based health reform is improved political accountability. In Massachusetts, for instance, state officials discovered that their initial idea for required insurance coverage resulted in premiums that were too high to subsidize within their state budget. To get costs down, the state had to reexamine benefit

mandates, set priorities, and allow greater consumer cost sharing. A broad-based political compromise was achieved only because all sides understood the financial limits within which they had to operate.

The U.S. system of health insurance coverage works well for most Americans, but a growing number, including millions of children, are falling through the inevitable cracks that emerge when favorable federal tax treatment is extended nearly exclusively to employer-based plans. Both the Bush administration and officials in the Massachusetts state government believe a better system requires, as a first step, extension of favorable federal tax treatment to coverage secured outside the traditional workplace setting. They are right. Congress and other states should take note and follow their lead. ■