INCREMENTAL STEPS TOWARD HEALTH SYSTEM REFORM

by Mark V. Pauly and John C. Goodman; Judith Feder and Larry Levitt; Stuart M. Butler; David M. Cutler; and Gail R. Wilensky

Prologue: *The failure to pass health system reform legislation in the 103d Congress taught the nation and its leaders several lessons. One of the clearest of these was that the nation does not yet have an appetite for comprehensive, sweeping changes in its health care system. Many problems remain, however, and in the absence of systemwide change, the nation can move toward solutions to these pressing problems. In this forum authors from across the political spectrum offer their prescription for reform in "bite-size chunks." First, Mark Pauly and John Goodman, of the University of Pennsylvania's Wharton School and the National Center for Policy Analysis, respectively, offer a proposal for medical savings accounts and tax credits, to allow the market to work better for individual purchase of health insurance. Next, Judith Feder and Larry Levitt of the Department of Health and Human Services present an agenda for achieving universal coverage in gradual steps over the next several years. These steps should be designed to minimize disruption in current insurance arrangements and should "be readily understood as improving the status quo," the authors write. Stuart Butler of the Heritage Foundation presents a conservative agenda for incremental health system reform, emphasizing competitive solutions, not government regulation and mandates. David Cutler of Harvard University and the National Bureau of Economic Research states the goals of incremental reform as cutting health care costs and improving the nation's health status. Finally, Gail Wilensky of Project HOPE, who is former head of the Health Care Financing Administration, presents an agenda for reforming Medicare, building on the program's past successes to bring it in line with innovations in the private insurance marketplace.*

Tax Credits For Health Insurance And Medical Savings Accounts

by Mark V. Pauly and John C. Goodman

With the demise of efforts for large-scale health care reform, policymakers have turned their attention to incremental reforms. Two reforms of particular interest are the use of the tax system to encourage the purchase of insurance coverage and the creation of medical savings accounts (MSAs). Here we outline a proposal to combine these devices in a way that strengthens the acceptability and desirability of catastrophic insurance coverage, structures MSAs so that they do not distort incentives, and avoids individual or employer mandates.

The basic objectives of our proposal are efficiency and equity. *Efficiency* does not necessarily mean less medical spending; it means that the benefits citizens get from medical services exceed their costs. One way to promote efficiency is to make sure that individuals' incentives are not distorted. Thus, beyond encouraging access to a basic level of medical care, public policy should be neutral, neither encouraging nor discouraging medical insurance or out-of-pocket medical spending relative to the consumption of other goods, or saving. *Equity* is more difficult to define. We assume that horizontal equity is a shared objective-people with the same income should be treated the same. Many people also believe in some sort of vertical equity, which usually implies helping low-income people more than higher-income people. Achieving this objective, however, usually reduces efficiency, because redistribution almost always distorts incentives.[1] We propose alternatives that limit this distortion.

Problems With The Current System Of Financing Private Insurance

The current tax system in the United States offers more favorable tax treatment to citizens who obtain their insurance in connection with employment, by excluding from federal income and payroll taxation the compensation that employers pay as fringe benefits. This creates inefficiency because of two kinds of distortions. First, the system favors the financing of medical services via insurance and offers a larger tax break the more costly the employer-provided insurance is. This creates incentives for people to devote more of their total compensation to insured medical services, rather than to uninsured services, other consumption, or savings. Second, this subsidy is available only to persons who work for employers that arrange such coverage. It is not available to the self-employed, the nonemployed, or people who work for firms that do not provide health insurance. Thus, it distorts an individual's choice in the labor market-which firm to work for and whether to work as an employee or as a self-employed person.

The subsidy also violates the principle of horizontal equity, since it offers larger tax breaks to some people, while it denies them to others earning the same incomes. Moreover, because the value of the exclusion rises with a person's marginal tax rate, the value of the tax subsidy is greater for higher-income workers than for lower-income workers.

Current tax policy makes it possible for people to reduce their income and payroll taxes if they elect more generous insurance policies. Defenders of the current system sometimes argue that it encourages the purchase of health insurance. However, it is not designed very well for this purpose. It creates no incentive for those who pay no taxes and creates only very weak incentives for those with low incomes and low marginal tax rates. Thus, it is no surprise that such lower-wage families make up a large fraction of the working uninsured. In short, the conventional argument analysts make against the current tax treatment of insurance is that it biases choices toward insured medical care and away from other ways in which citizens could spend their income, and it does so in an unfair way.[2] These problems could be eliminated by repealing the exclusion, taxing employer premium payments as part of wages, and using any revenue increase to lower taxes. However, this tax advantage has substantial political durability.

Analysts therefore have been searching for a policy that does not tackle the tax exclusion head on, but instead tries to eliminate some of its most harmful effects without running into a political firestorm. Such a policy would not be as efficient as complete elimination of the exclusion but could still do a substantial amount of good.

In this paper we propose tax credits for the purchase of combinations of catastrophic coverage and MSAs.[3] Instead of abolishing the current tax advantages, we propose to make a new system available to individuals and groups as a voluntarily chosen substitute for the existing tax treatment of health insurance. We believe that we have combined the various elements in a way that eliminates many of the distortions caused by a tax subsidy for third-party payment of medical bills and yet guards against the possibility that people could use MSAs to shelter out-of-pocket spending on medical care. Our plan reduces the likelihood that they will purchase catastrophic coverage with deductibles too high to be affordable.

Three policy goals. We propose to change incentives so that citizens will make the right choices along the fine line between appropriate medical care and excessive use of services. To achieve this objective, public policy should encourage adequate insurance coverage, appropriate resources to pay for out-of-pocket expenses, and fair and efficient financing. These three broad goals are achieved by (1) fixed-dollar tax credits to reward those who voluntarily purchase insurance; (2) basic catastrophic insurance coverage to cover large medical bills; and (3) MSAs to pay small medical bills and to

offer rewards for prudent purchasing decisions.

These three characteristics complement each other. Catastrophic coverage provides protection against the risk of incurring large medical bills above a deductible. The ability to choose higher deductibles without tax penalty gives families proper incentives to hold down the cost of insurance. And when they pay small medical bills from their own resources, they have incentives to make wise purchases. A way to fund medical expenses below the deductible is to have an earmarked savings account. We propose a tax credit to help all families pay for insurance and finance their MSAs. It offers a specific dollar reduction in taxes (or a refund or voucher, if the family owes no taxes) for those families who obtain at least the catastrophic coverage. The tax credit would be a fixed-dollar or predetermined amount; families would not receive more relief if they purchased more generous insurance coverage or added to their MSAs.

So we have a decent insurance policy, a spending account to permit rational decisions on out-of-pocket amounts not covered by the policy, and a tax credit to help finance medical care in a nondistortive and fair way. In what follows we explain why these three pieces make possible major gains in solving the health care spending jigsaw puzzle, offer some examples of how they might work in practice, and predict what the impacts of these changes might be.

Health Insurance: Protecting Resources Or Distorting Incentives?

In redesigning tax policy toward medical care, there are two approaches one might take. One approach is to use tax policy to direct citizens toward types of care or insurance that have already been determined, by experts or by politicians, to be socially appropriate. We specifically reject this approach, because the current state of knowledge does not permit determination of what types of medical services are best for everyone and because a choice as personal as medical care ought to be left up to citizens, not tailored by government. The other approach is to provide citizens with the financial means and the information needed to make good choices, without distorting their incentives. This approach is more suitable to public policy in a democracy in which voters are treated as adults, able to make rational and responsible choices in their personal lives just as they do in the political process.

Political decisionmakers must resist the temptation to engineer choices for other citizens, even at the cost of seeing people make choices that the decisionmakers would not make for them or that they think are unwise. Government policy should be one of neutral incentives. That is, as much as is possible, policy should ensure that people face prices for insurance and for

medical care that reflect true costs.

All third-party insurance contains an inherent distortion. We cannot avoid this distortion, but we can contain it. From the point of view of risk-averse consumers, there is a demand for insurance against the unpredictable cost of medical care. But when insurance pays for medical care, consumers need not consider the cost of the services, even though any costs they incur will eventually raise premiums,

To minimize this distortion, one good idea is for people to buy insurance that covers only large medical expenses and permits them to pay out of pocket for smaller ones. (The other alternative is managed care, which offers incentives to doctors to refuse or discourage low-value services.) People should be able to make their own choices about how much risk they will accept and how much they will transfer to insurance, as long as that exposure does not create unreasonable financial burdens for others or cause moral burdens that might stem from seeing some people go without needed care. The primary social objective here, in our view, is not to discourage people from accepting risk they find tolerable, but instead to help them handle that risk in a way that makes them take costs into account and benefit from efforts to limit those costs. The best way to achieve this objective is to permit people to purchase catastrophic coverage with relatively high deductibles, but to make it possible for them to finance those payments as efficiently as possible.

MSAs and catastrophic insurance. Individual MSAs to pay medical bills are already used by a number of firms and their employees.[4] The idea is simple. Instead of buying expensive, full-coverage policies, obtain catastrophic insurance. But instead of incurring the risk of high out-of-pocket payments with no assets to cover them, create a special account with after-tax dollars, earmarked to cover those expenses. The availability of this account will mean that a family will not have to risk incurring bad debts and defaulting on their obligation to pay for the care they receive.

With an MSA, even a family of moderate income could tolerate insurance with a substantial deductible, thus holding down the insurance premium they have to pay and the administrative expense associated with insured expenses. From a social point of view, deductibles judged unacceptable become tolerable cost containment devices when joined with an MSA. Families should be free to decide to pay for coverage with lower deductibles, for more protection against risk, if that is how they prefer to spend their money. But the combination of an MSA and catastrophic coverage will, we expect, appeal to many and surely should not be inhibited by tax incentives as is now the case.

MSAs have a further administrative and social advantage. No one wishes to encourage the current situation in which a significant minority of

middle-class families find themselves without any insurance and counting on the charity of providers and their fellow citizens if they need costly care. Such bad debtors impose a burden on someone, either providers or other consumers. Firms that sometimes sell on credit often give discounts to buyers they are sure will pay, so integrating an MSA with a catastrophic policy should permit an insurer administering a catastrophic policy to get a better price from providers and transfer this advantage to consumers. A discount for fiscal responsibility should benefit everyone.

People obviously can and should use the funds in their MSAs for their deductibles. However, they should be able to withdraw unused funds for other purposes at the end of any insurance year. The fact that this account (like any savings account) can eventually be used for purposes other than medical services means that there are strong and proper incentives to avoid medical services that are not worth their cost. In contrast to the current system, a family is able to finance highly valuable care but is deterred from obtaining care of low benefit relative to its cost.

The ideal MSA does not distort incentives. The taxes a family pays should be neither higher nor lower if the family chooses an MSA accompanied by catastrophic coverage rather than managed care or conventional insurance with lower deductibles. Some MSA proposals extend the tax exclusion now limited to employer premium payments to uninsured medical spending made out of MSAs. This removes the distorted incentive to overinsure, but at the risk of offering incentives to overconsume medical services paid out of an MSA.[5] The MSA proposal described below avoids both of these distortions by making a person's taxes (after the MSA is set up) independent of how much he or she deposits in or spends out of an MSA. This is accomplished by designing the program so that MSA deposits come from after-tax dollars, just as do expenditures on health insurance, other current consumption, or other mechanisms for saving and investing.

Tax incentives and tax credits. As noted earlier, the current tax subsidy does not offer well-designed incentives to purchase health insurance. There is a better way for government to encourage the purchase of some health insurance by all Americans. The subsidy should take the form of a fixed-dollar tax credit, contingent on the purchase of at least basic catastrophic insurance coverage. The tax credit is fixed in the sense that qualifying for it depends only on securing insurance, and the amount of the credit does not become larger when more costly insurance packages or larger amounts of medical care are purchased.

The tax credit is not for buying catastrophic coverage and depositing in the MSA per se, but is for obtaining an adequate package of savings accounts and insurance coverage. It is not intended to encourage any particular form of insurance. People who purchase benefits above the basic

minimum will be paying entirely with their own resources, not shifting the cost of such purchases to others via the Treasury.

The credit is intended to help families set up and maintain an MSA and purchase insurance but is not itself intended to fully fund the insurance and care for families above the poverty line. Rather, it is both fair and efficient for families to use some of their own income for paying for the insurance they choose.

Another advantage of the tax credit approach is that it can be made available to all citizens, regardless of their employment status. This removes the distortion and inequity associated with subsidizing only those who are labeled "employees." Indeed, the most sensible first step might be to make tax credits available to the self-employed as a substitute for the temporary 25 percent insurance deduction that expired as health care reform collapsed in late 1994. A tax credit would be more rational on its own merits; also, the same tax break would be offered regardless of whether an insured person worked as an employee or decided to become self-employed, which would end tax-related "job lock."

Closing the exclusion loophole voluntarily. If we were devising tax policy toward health insurance from the start, we would propose tax credits for catastrophic coverage and MSAs as the only (minimal) government intervention in citizens' choices about medical care and medical insurance. However, the U.S. tax system provides a subsidy of nearly $100 billion per year to people who buy private health insurance through their employer. Removing the tax subsidy by wholesale revisions of the tax code seems politically improbable and likely to do inappropriate harm to people who made their employment choices based in part on expectations about the tax advantages of the fringe benefit packages some firms offer. While we do not therefore want to snatch away the tax exclusion, we do want to persuade people, voluntarily, to trade it in for a tax system with better incentives. This can be done by creating the option for groups and individuals to give up the old system of exclusions and take a refundable tax credit instead. If

Exhibit 1
Detailed Calculations Of Cost Implications Of Medical Savings Accounts (MSAs)

	Old policy	New policy	Difference
1. Premium	$2,500	$1,400	-$1,100
2. Deductible (maximum)	500	2,000	1,500
3. MSA deposit	0	1,100	1,100
4. Expected values of expenses beneath deductible	400	700	300
Total expected expenses (Line 1 + Line 4)	2,900	2,100	-800
Net maximum exposure (Line 2 - Line 3)	500	900	400

Source: Authors' calculations.

we are right that a fixed-dollar tax credit really is better for people than the old distortive subsidies, we should find many people willing to switch.

We illustrate how and why this would happen with a simple example.[6] Imagine a medium-size firm with workers who all earn close to the median annual wage. This firm now pays part of its compensation in the form of a fully paid health insurance policy that covers the employee only, with a $500 deductible. The tax subsidy to this policy is assumed to be about $750 per year.' Expected or average expenses under this plan are assumed to be approximately $2,900. We propose an alternative for the firm's workers: Pay income and payroll tax on the $2,500 employer premium and receive instead a personal income tax credit of $750 per person. The requirement to qualify for the credits is that employees obtain at least a catastrophic policy with a specified maximum deductible and protect the deductible by establishing or maintaining an MSA with after-tax dollars[8]

For example, assume that a catastrophic policy with a $2,000 deductible, rather than the $500 deductible, reduces the premium by $1,100. By depositing this $1,100 in an MSA, each employee would have funds immediately available for the first $1,100 of medical expenses. The next $900 would be paid out of pocket, as shown in Exhibit 1.[9]

The expected or average value of all health expenditures is assumed to drop by $800, from $2,900 to $2,100, when the deductible is increased from $500 to $2,000. So although the maximum exposure to uninsured expenses is increased by $400 (from $500 to $900), in return the average saving in total health care spending is twice as great, at $800.[10]

If the employees agree to give up the tax exclusion (and therefore pay taxes on the part of their compensation that formerly went to employer-paid health insurance premiums), they will pay $750 more in income and payroll taxes (on an additional $2,500 in money income) but will receive an exactly offsetting $750 personal income tax credit. They could remain with their old policy and be no better or worse off than before. But by electing the catastrophic coverage/MSA combination, they would save, on average, $800 on medical care and medical insurance.

To be sure, employees could have chosen to set up an MSA and purchase catastrophic coverage under current tax laws. But if they did so, and reduced their premium by $1,100, they would have to pay additional taxes on the higher money wages. The additional taxes ($330 at a 30 percent marginal rate) would wipe out 41 percent of the $800 savings on medical expenses. Under current law they would be deterred from making this choice, because they would have to share their savings with the government. Under the tax credit, in strong contrast, they would keep all of the savings, since they would receive the same $750 credit regardless of whether they chose the catastrophic or the low-deductible policy.

Additional Policy Choices

So far we have presented the broad outlines of an MSA/minimum catastrophic insurance proposal. We now describe some additional policy decisions needed to implement that proposal.

Individual versus group choice. Should individual employees be allowed to exercise the tax credit option, or should the entire group be required to do so? The latter strategy probably would induce the largest number of people to join the new, efficient tax system. Allowing individual employees to declare "employer contributions" as taxable income and receive a credit in return would not lead directly to a change in the types of coverage offered if only some took advantage of it. (However, permitting individual employees to "defect" might be less cumbersome than requiring a group decision and would eventually put pressure on the group.)

It should be noted that this change in tax treatment in no sense gives individual employees the "right" to opt out of a group and demand a full premium refund. Employers or unions may still choose to require all employees to participate in the group plan (by the financial device of making premium payments for each employee before the money wage paycheck is written). Such group purchases can hold down the administrative cost of insurance, provide a form of risk spreading that is not possible with individual insurance purchases, and inhibit adverse selection.

Putting limits on deductibles not covered by MSAs. As the numerical example suggests, there can be a gap between the MSA balance and the insurance deductible. This gap represents an "out-of-pocket" risk for the individual. Since one of the purposes of public subsidies for medical insurance is to encourage people to limit their exposure to risk, one could argue that there should be some upper limit on the size of out-of-pocket exposure people are allowed to have and still qualify for a tax credit. There also may be an argument for limiting lower-income families to smaller out-of-pocket maximum amounts, since out-of-pocket payments may deter them from obtaining the most beneficial care.

Putting limits on the catastrophic deductible. There may also be good

Exhibit 2
Examples Of Maximum Deductible And Out-Of-Pocket Limits Under A Medical Savings Account (MSA) Proposal

	Option A	Option B
Maximum deductible	$3,000	$2,000
Maximum out-of-pocket payment	1,000	500
Minimum MSA balance	2,000	1,500

Source: Authors' calculations.

reason to restrict the size of the deductible. Someone who chooses a $100,000 deductible and deposits $100,000 in an MSA is obviously using the MSA to shelter interest earnings rather than attempting to achieve an optimal allocation of risk. (The premium savings become quite small as the deductible grows beyond $3,000.) In addition, it probably would not be desirable to permit a lower-income family to select a policy with a very high deductible and put their entire life savings into an MSA, since fear of wiping out their assets may deter them from seeking beneficial care.

The precise deductible/MSA combination a family at a given income level should be required to have in order to qualify for a tax credit is a policy decision. The lower we make the maximum deductible, the less likely the chance of underuse of beneficial care, but the greater the chance of overuse of less valuable care. Moreover, the higher the required MSA deposit, the more likely that lower-income families would opt to forgo insurance (even with a credit), unless they received a very generous credit.

Putting the pieces together. A simple version of the plan would entitle people to a $750 tax credit if they are not receiving a tax-shielded employer contribution and if they buy insurance with a deductible no greater than some amount protected by an MSA with no more than some (smaller) amount to be paid out of pocket. Exhibit 2 gives examples of two such specifications. Such an easy-to-understand message sets a floor to the coverage people must have to receive a tax credit, permits (but does not require) them to purchase more coverage if they wish, and helps via a tax credit. The fixed-dollar tax credit has the desirable incentive property that if persons contemplate buying more generous coverage than the minimum, they are certainly not forbidden from doing so, but they receive no additional tax reduction if they do; they will be paying with their own money.

Tax treatment of rollovers. The only tax break in this plan so far is the tax credit. If persons deposit $2,000 in their MSA in the first period and use no medical care, they will have available $2,000 plus interest at the end of the period. Since the MSA was created with after-tax dollars, they could use these funds for any purpose. To offer an incentive to retain the funds in the MSA, the plan would offer the same $750 credit for the next period if the same MSA/catastrophic insurance combination was maintained. (A person would not need to add another $2,000 to an MSA if he or she carried over the previous period's protection.) In addition, it may be desirable, as an optional design feature, to permit the interest to be rolled over or withdrawn without tax penalty. If it **is** desired to limit the Treasury's revenue loss on tax-free interest, there would be a maximum amount that an MSA could earn tax free.

Varying the tax credits by income. There is also a design challenge in scaling the credit with income. Since the current tax exclusion rises moder-

ately with income, to get maximum participation of persons who now enjoy the tax exclusion, the credit should increase with income (as marginal tax rates increase). But this will offer little incentive for participation by lower-income families-since they benefit little from the current exclusion. To get them to participate in greater numbers, the credit should be large for lower-income families, especially if the goal is for them to obtain more generous coverage.

Offering lower- and middle-income families credits larger than the $750 target has a cost to other taxpayers. In addition, there is a cost in that work effort is deterred, since high effective marginal tax rates are created if the value of the credit is scaled down as income rises. However, if such income-related refundable tax credits replace current Medicaid, they offer the possibility of reducing deterrent effects of the Medicaid phaseout.

Tax Credits, MSAs, And Managed Care

The argument for MSAs and tax credits is not limited to their encouragement of catastrophic coverage as a cost containment device. They also would help to encourage the use of appropriate forms of managed care and would discourage the use of inappropriate forms. Just as catastrophic coverage contains costs by putting people at risk for paying for care, managed care contains costs by putting people at risk for rationing of care by limiting access to care that is judged by an insurance plan to be worth less than its cost. Under the principle of incentive-neutrality, we do not want tax policy to favor either type of cost containment device. Different people, with different preferences, will appropriately choose one or the other.

However, current tax policy governing the choices between managed care and catastrophic coverage in the employment setting is not neutral, and the choices among managed care plans are distorted as well. If an employee group chooses a managed care plan with low out-of-pocket payments under current tax treatment, virtually all medical expenses are tax subsidized. If it chooses catastrophic coverage that contains costs more effectively, there will be a smaller exclusion of compensation from federal taxes-and so the more effective insurance policy will be penalized. If the group is choosing between two managed care plans-one more costly and more lavish, the other less costly but somewhat more inconvenient or constraining–choosing the less costly plan will raise its members' taxes. This loss of the tax subsidy will bias the group away from lower-cost managed care plans.

The arrangement we have proposed avoids both of these biases, because the tax credit is independent of the type of insurance chosen. In the choice between managed care and catastrophic coverage, the tax credit is not

increased if the managed care plan is chosen; the tax credit "covers" both the insurance premium and the out-of-pocket expenditures from an MSA. In the choice between more and less expensive managed care plans, the tax credit does not fall for those who choose a less attractive but less costly plan or rise for those who purchase a more costly plan. Under our proposal, we expect that many people would voluntarily choose managed care plans. Since people do not have to share their savings with the government, they would face proper incentives.

In addition, our proposal is consistent with the recent trend in managed care to increase out-of-pocket payments, either as user charges or as extra payments for people who exercise a point-of-service option and pay out of pocket to use nonnetwork providers. Under our proposal, MSA funds can cover the "risk" that individuals will decide, once they are sick, to see a doctor or enter a hospital not in the managed care plan's network.

The Problem Of Adverse Selection

Some critics fear that increased use of catastrophic insurance coverage protected by MSAs will worsen a serious social problem of risk segmentation and adverse selection in the private health insurance market. A similar argument has been made over the years against all innovative forms of private insurance, most especially against health maintenance organizations (HMOs)–which do seem, in some circumstances, to be attractive to low risks. The natural tendency in competitive insurance markets is for premiums to reflect risks. To the degree that this process creates unreasonable burdens for some people, government interventions such as tax-financed risk pools or risk-related tax credits for unusually high risks are the correct solutions. The alternative strategy, using regulation to forbid insurers from pricing risk, will itself have undesirable consequences-it either will induce insurers to avoid bad risks and to attract good risks (thereby causing even worse adverse selection) or will offer incentives to good risks to purchase too much insurance. A full treatment of this exceedingly complex and confusing issue is beyond the scope of this paper,"

There is little reason to believe that the specific form of tax credits we have proposed will alter the situation appreciably, however. Our proposal is limited to solving what we believe to be the more serious problem of tax-distorted insurance, and it need not worsen current levels of risk seg mentation. Under our proposal, we expect that the vast majority of insured people will continue to obtain their health insurance through employment-based groups.[12] As noted above, our proposal would permit employers or unions to continue to require payment for group health insurance as part of the compensation package. If the group switched to a higher-deductible

plan and all employees were switched, higher-risk employees would continue to be members of the same group as lower-risk employees. And all would have access to an MSA to meet expenses below the deductible. Moreover, our proposal offers those who most typically drop out of the current insurance system-young, healthy, but low-wage workers-a larger subsidy to stay in and obtain catastrophic coverage. Our plan also offers persons at all risk levels, including the small minority at high risk, the option of a credit toward a decent minimum insurance policy.

If the group decides to allow individual employee choice between a high-deductible and a low-deductible (or managed care) option, it would be expected to adjust the premium differential between options to limit adverse selection or excessive risk segmentation, since such behavior is not in the interest of the employer, the union, the employee group, or whoever is arranging the terms of coverage. Thus, even if better risks choose catastrophic coverage and other risks stick with more generous but more expensive coverage, there need not be negative consequences.

To be sure, the employer or union may decide that the advantages of risk pooling are not as great as the advantages of individual choice in the individual insurance market, which can better tailor coverage to individual demands. In that case, they might no longer require universal participation, or they might no longer discourage dropouts by returning only a fraction of premiums to those who forgo coverage. The tax incentives we have designed are neutral in this regard. We do not wish to encourage or discourage employers or unions from being in the health insurance business. But this trade-off is one of many that the group would have to make, and should be trusted to make, under proper incentives.

Finally, in the individual market, people are already free to select high-deductible options and often do so. The availability of MSAs therefore is unlikely to further affect the risk segmentation in this market.

Impact On The Budget And The Economy

A required exercise in Washington for any health care reform proposal is the "scoring" of its impact on the budget. We believe that the desirability of the qualitative characteristics of the plan we have outlined does not in any way depend on how it scores. If a plan with these characteristics appears to the taxpayers to cost too much, some less costly plan with a smaller tax credit-but one that still represents an improvement over the current state of affairs-can be substituted.

However, a voluntary plan with a tax credit close to the current average tax subsidy need not increase the federal deficit. Such a credit should appeal to workers whose current tax exclusion is close in dollar level to the tax

credit. For those persons, the impact on the Treasury is roughly neutral, since the tax credit is just offset by tax collections on what were formerly tax-excluded employer contributions. The real benefit, to citizens and to the economy, comes from lower spending on medical care, which will occur when people have the opportunity to choose between medical care and other goods and services on a level playing field.

People at higher income levels, who will pay more taxes than they receive in credits, may still make the trade. They might do so because the savings on their medical spending will more than offset any extra taxes they would have to pay. In the numerical example discussed earlier, a person at a high marginal income tax bracket would have to pay about $400 more in taxes as a result of trading in the tax exclusion. Yet the reduction in average or expected medical expenses from switching from a lavish conventional insurance policy to a more rational catastrophic/MSA combination would be on the order of $800.[13] If such persons do decide to switch the exclusion for a tax credit, they will pay more to the Treasury.

The Treasury will lose money on lower-wage workers who trade in a tax exclusion of lower value for the more generous tax credit. Some of these workers will be insured for the first time, however, and there will be social gain from that fact. Moreover, the drain on the Treasury only represents a more equitable and more efficient way of treating lower-wage workers. Delivering a tax cut in this fashion does two good things: It reduces the government's bite on people who cannot afford high taxes, and it also helps them to afford protection against medical care costs.

Will trading in a tax exclusion for a tax credit and a lower-cost insurance policy really appeal to many people at moderate income levels? The answer depends critically on the answer to another question: How serious is the distortion in insurance choices now produced by the tax exclusion? Economics suggests that the distortion is substantial, which implies that reasonable consumers will be attracted by an opportunity to save money by seeking the tax credit and changing their insurance. If economics is wrong, and people buy the same insurance plan no matter what the tax advantages, then removing the exclusion will not cut medical costs (although it will quiet the chorus of economists), but it will not cause any harm.

Conclusion

One thing we learned from the roiling debate on health care reform is that there are no magic bullets to solve the health care problem. In this paper we have outlined a plan for a careful combination of some of the good ingredients. MSAs, tax credits, and catastrophic coverage all have to carry the freight, and no one component is more important than any other.

Given the maturing of the debate that has occurred, we believe that this combination approach can appeal to the electorate and can be seen as a good step in the right direction.

NOTES

1. For further discussion of these objectives, see M.V. Pauly et al., "A Plan for 'Responsible National Health Insurance'," *Health Affairs* (Spring 1991): 5-25.
2. See M. Feldstein and B. Friedman, "Tax Subsidies, the Rational Demand for Insurance, and the Health Care Crisis," *Journal of Public Economics* (April 1977): 155-178; M. Pauly, "Taxation, Health Insurance, and Market Failure in the Medical Economy," *Journal of Economic Literature* (June 1986): 629-675; Congressional Budget Office, *The Tax Treatment of Employer Based Health Insurance* (Washington: CBO, March 1994); and S. Glied, *Revising the Tax Treatment of Employer-Provided Health Insurance* (Washington: AEI Press, 1994).
3. For a description of MSAs, see J. Goodman and G. Musgrave, *Patient Power: The Free Enterprise Alternative to Clinton's Health Plan* (Washington: Cato Institute, 1994).
4. See National Center for Policy Analysis, "Medical Savings Accounts: The Private Sector Already Has Them," NCPA Brief Analysis 105 (Washington: NCPA, 20 April 1994). Regarding the problems of eliminating distortions through MSA design, see J.C. Goodman and G.L. Musgrave, "The Economic Case for Medical Savings Accounts" (Paper presented to the American Enterprise Institute, 18 April 1994).
5. M. Pauly, An Analysis of Medical Savings Accounts: Do Two Wrongs Make a Right? (Washington: American Enterprise Institute, 1994).
6. The numbers are purely illustrative, but they are chosen to be reasonable. 'The example could be modified to illustrate family coverage.
7. This is approximately the value of the tax exclusion if the employee's marginal income tax rate is 15 percent (combined with the 15 percent payroll tax rate) and the employer contribution toward an individual's insurance is $2,500.
8. The method by which the account to protect the deductible would be created would be determined by the insurer; insurers might require an initial deposit of $2,000 (less any permitted out-of-pocket amount) or might collect the deposit in installments, along with the insurance premium. The key requirement is that the minimum MSA balance cover any large expense incurred in the first month of coverage.
9. As indicated in the first column of Exhibit 1, the original policy has a $500 deductible, a $2,500 premium, and the average or expected expense of $2,900. As indicated in the second column, moving to a policy with a $2,000 deductible would lead to a premium savings of $1,100-a sum that may be deposited in an MSA. The third column shows that at the higher deductible (partly protected by the MSA), the maximum individual expense for out-of-pocket spending has increased by $400. However, total expected spending on medical care will be reduced by $800.
10. This implies that the new lower premium, $1,400, covers 67 percent of all expenses and that expected expenses under the deductible rise from $400 to $700.
11. See M.V. Pauly, "Killing with Kindness: Why Some Forms of Managed Competition Might Needlessly Stifle Competitive Managed Care," in *Health Policy Reform: Competition and Controls,* ed. R. Helms (Washington: AEI Press, 1993), 149-175.
12. For most people the substantially lower administrative cost for group insurance (compared with individual insurance) is at least as large an advantage as is the tax subsidy.
13. The value of the tax exclusion of $2,500 in premium at a marginal income tax rate of 31 percent (plus the 15 percent payroll tax) is $1,150, $400 more than the $750 for the 15 percent income tax rate in our example.