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Keeping Health Insurance Tax Credits on the Table

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IN THIS ISSUE OF THE JOURNAL, THE PUBLICATION OF THE most recent version of the American Medical Association's (AMA's) proposal¹ to reduce the number of Americans without health insurance comes at a good time. In the early stages of the presidential campaign, health care has been identified as a priority issue, and the trends in escalating medical premiums and the increasing proportion of the population that is uninsured are also of concern. The AMA has tried to develop an approach that would make a major contribution to enhancing access in private insurance; it does not pursue the idealistic but probably (given the current political and public finance environment) infeasible goal of universal coverage right now. Even so, by extrapolating past trends on increasing private insurance coverage, it is clear that the proposal will have to address several challenges—some are economic, some are fiscal, and the most serious ones involve politics and policy in a democracy.

The Physicians' Working Group (PWG) has previously made its proposal in THE JOURNAL,² and Fein commented that it would be helpful to renew the debate on the uninsured.³ How does the AMA proposal contribute to that debate?

The logic behind the proposal is economically attractive, which is not the same as politically attractive. Many of those who are uninsured are not high medical risk and are not poor.⁴ They could in principle gain from and pay something for insurance that truly averages the cost of uncertain medical events; insurance for the uninsured can be more than just a pure transfer. Many Americans younger than 65 years do obtain private insurance, and most of the uninsured had such coverage at some point.⁵ The economically logical (and common-sense) hypothesis behind the AMA proposal is that the reason the uninsured lack coverage is because they judge the price they would have to pay for insurance too high relative to the benefits they expect to obtain. Some of the uninsured are poor; paying the full premium for insurance would bite too deeply into their household budgets. Some are not poor but have reasons to

find spending money on insurance less attractive than taking a chance on paying out of pocket or obtaining care in some other way. Presumably they would prefer to be insured if the price were low enough, but it is not.

The solution to the problem defined in this way is to use subsidies to make insurance cheaper for this segment of the population. This approach has simplicity as a virtue, even though some critics claim that it is too simple. The size of the subsidy needed to insure a large proportion of the uninsured is an empirical issue about which there is considerable imprecision in data and therefore disagreement in policy, but the principle that sufficiently lower premiums should help can hardly be denied.

The idea of using tax credits, inversely scaled to income as proposed here, has been proposed by the AMA and others (including both Bush administrations) for decades.^{6,7} There is a small program to offer tax credits (unrelated to income) under the Trade Assistance Act to those who lose their jobs because of imports. That these proposals have yet to advance in more than a token way is not necessarily a fatal flaw, because other approaches to expanding coverage for the bulk of the population have also been stymied. Nevertheless, it is reasonable to ask whether the new proposal by the AMA might move forward. Is there something in its rationale, or in the current economic and political environment, that would give it a chance? Or are there impediments that need to be identified and perhaps overcome first?

While some impediments are technical (as discussed in the article), the major one is ideological. The most proximate version of the ideological question concerns the role of markets vs government: should health insurance be provided through the private market or through government? Attitudes toward this question are often based on deep-seated preconceptions.

The AMA proposal attempts to solve this problem by allowing, and even encouraging, governments at all levels to make collectively chosen and publicly managed plans available to holders of credits, along with private insurance plans.

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See also p 2237.

States might offer enrollment in the plans chosen for state employees or in the plans they offer to their Medicaid beneficiaries. This “2-track” approach should help defuse the ideological conflict, except among those who think citizens should be forbidden to use private insurance.

Offering choice probably will entail higher administrative cost than having a single compulsory plan. However, ample evidence, such as the political failure of the Clinton proposal and employee resistance to employers forcing low coverage or strictly managed plans, suggests that people do value the choice of health plan. Some consumers are willing to accept restrictions to have lower premiums and more cost containment, but others (so far) are not. The AMA plan would leave the choice of degree of restriction (which is sure to increase on average as medical spending increases in real terms) up to consumers in the market, rather than decided at a uniform level, for all citizens, in the political arena.

The AMA proposal is not only to help the uninsured, however. In proposing replacement of the current tax exclusion for employment-based coverage with a credit, it takes a major step toward cost containment. Of course, that step is politically dangerous because it occurs not among the small minority who are uninsured, but among the much larger fraction of the population who are the real source of higher spending: heavily subsidized, well-insured upper-middle-class citizens. Through a variety of tax exclusions, this group can share the cost of prescription eyewear and the latest costly medical technology with the US Treasury by the use of tax-shielded insurance premiums and spending accounts. Increasing costs and premiums driven by these upper-middle-class choices also appear to push more and more of the less well-off into the ranks of the uninsured. The AMA proposal may set the stage for a neglected but crucial debate: what those who are not poor are willing to give up in the interests of efficiency and equity in health care.

The nonpoor portion of the population will have to be approached for another fiscal matter, addressed in the proposal. Any realistic program to make a major dent in the numbers of uninsured through tax credits will have a substantial budgetary cost, almost surely at the level of \$50 billion per year or more, as the proposal notes. Taxpayers, who are almost all privately insured, must be convinced that paying higher taxes or sacrificing some other type of government spending to help the uninsured is worthwhile. Despite enormous effort to urge coverage of the uninsured, the major organizations concerned with this question have not made a serious effort to address the honest skeptics who ask whether, of all the things that might help those in the lower income brackets, health insurance is necessarily at the top of the list. But in this debate, care must be taken not to fixate on the pure budgetary cost and instead it should be noted that credits claimed by low-income people who currently are insured, far from being “wasted,” represent tax cuts that they surely deserve as much as the formerly uninsured.⁸

The AMA proposal makes a major contribution in dealing with the numerous red herrings that confuse the de-

bate that should be ongoing. It shows that it is possible to design private insurance to protect high risks, by inducing individuals to buy insurance before they contract chronic conditions and then protecting them from further underwriting through guaranteed renewability provisions. It shows that it is possible to provide health insurance to workers that is not dependent on what the employer decides to select or that is changed or lost if jobs are changed. It shows that credits should be offered to everyone who obtains decent insurance, regardless of how they obtain that insurance, thus avoiding biases toward either group or individual coverage. It shows that there are more important economic issues than pure administrative cost—an inexpensive insurance plan no one likes or wants is no bargain.

In the debate on the ways to reduce the number of uninsured individuals, the AMA proposal helps by ensuring that an adequately funded tax credit proposal remains on the table. This proposal crosses ideological wires, in offering redistribution from rich to poor and the availability of publicly produced options, but in the context of a lightly regulated (but by no means unregulated) private insurance market. On paper, such a proposal looks much less tidy than the PWG approach, which asserts and assumes that the government will act in certain efficient and equitable ways. The gain from this imprecision is precisely the greater flexibility markets offer to an American population that has shown itself to be decidedly uninterested in being told what insurance to purchase and what care to receive. Moreover, whatever is written as a plan, it is eminently reasonable to monitor the actual implementation of a credit system and to make changes if serious adverse effects arise. It will be easier to admit mistakes in a private system, and it will also be easier to make modifications that improve matters. The AMA plan envisions that the low-income uninsured will be able to spend their money on health insurance they like, and that the upper-income insured will stop spending other people’s money on insurance they are tempted into buying. The debate over how to combine access to insurance with cost containment needs to take this radical point of view into account.

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