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**POLICY** STUDY

# GETTING OUT OF OUR HEALTH INSURANCE QUAGMIRE

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# SUMMARY

Per-capita spending on health care in the U.S. is the highest in the world, and it is not clear that this high spending generates additional health benefits, suggesting that our health care system is inefficient and can be improved to save costs and/or to improve outcomes. We have high and rising health insurance premiums, a large group of uninsured citizens, and a fair bit of inequality in the delivery of health care.

The authors argue that much of these inefficiencies in health care are due to government policies that are ill-designed and that cause or contribute to our health care problems. This study offers an outline of efficiency-enhancing reforms aimed at addressing these problems, including replacing the tax exclusion on employer-provided health insurance with tax credits, using the health saving account to strengthen cost-saving incentives, keeping government mandates in check, and ensuring pricing transparency to better achieve greater cost-consciousness among both providers and patients.

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# GETTING OUT OF OUR HEALTH INSURANCE QUAGMIRE

## INTRODUCTION

In the ongoing health care policy debate, the same issues that have been discussed in the past continue to dominate the debate today. How do we pay for health care? Can we lower health care's share of the economy without reducing the quality of health outcomes? Can we or should we attempt to reduce the growth rate in per capita health care expenditures? How do we ensure access to health care for people with different health status, different ages, and different incomes?

This study discusses the main problems in U.S. health care delivery, with an emphasis on the health insurance market. It argues that in many cases, ill-designed government policies towards health insurance are responsible for these problems.

Health care spending in the U.S. as a percent of GDP has grown from 5% in 1960 to 17.9% in 2017 and is forecast to reach 25% by 2040.[1] The growth rate in health care spending has outpaced the growth rate in GDP for decades. This growth in health care expenditures puts great strain on government budgets and bears more than a little responsibility for our current ongoing federal budget deficits. For example, federal government spending on "major health care programs" as a percent of GDP has grown from 0.8% in 1969 to an estimated 5.2% in 2019 and is forecast to reach 9.3% in 2049.[2]

Health care in the U.S. is expensive – in 2015 we spent $9,450 per person on health care. By comparison, the country with the second highest level of per capita spending, Switzerland, spent $6,930 per person. The average spending per person in the OECD countries was $3,740 per person.[3]

Are we getting better care for our extra spending? While that is a question without a clear answer, we do observe that the life expectancy at birth in the U.S. was 78.8 in 2014, while the average life expectancy across the OECD countries was 80.8.[4] We may well be buying better care, but we are not buying more years of life compared to other nations.

Health care differs from most other goods and services in that it is provided predominantly through the intermediation of health insurance. Insurance per se improves the well-being of the insured by forming an insurance pool where the insured pay a premium and those who incur a loss due to an unforeseen event get partially compensated from the pool of premiums. In the U.S., 91.2% of people had health insurance coverage of some kind during at least part of 2017, with 67.2% covered by a private plan (either an employer-based plan or a direct-purchase plan) and 37.7% covered by some government plan (either Medicare, Medicaid or military health care).[5]

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[1] "National Health Expenditure Data" from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html, and "The Long-term Assumptions for Medicare and Aggregate National Health Expenditures" by Stephen K. Heffler, Todd G. Caldis, Sheila D. Smith, and Gigi A. Cuckler, Memorandum, Centers of Medicare and Medicaid Services, Office of the Actuary, June 22, 2016.

[2] "The 2019 Long-Term Budget Outlook," Congressional Budget Office, June 2019.

[3] "Health Spending", in *Society at a Glance 2016: OECD Social Indicators*, OECD Publishing, Paris.

[4] "Health Spending", in *Society at a Glance 2016: OECD Social Indicators*, OECD Publishing, Paris.

[5] Some people have multiple plans, so these percentages add to greater than 100%. See Edward R. Berchick, Emily Hood, and Jessica C. Barnett, "Health Insurance Coverage in the United States: 2017", U.S. Census Bureau, September 2018.

In a perfect world, individuals would make insurance purchasing decisions, and insurance providers would formulate insurance policies in response to demand with both sides of the market facing undistorted price signals. The outcomes resulting from such a market would be mutually beneficial. Insurance is seldom complete, and the reason for this is the so-called "moral hazard" problem – the tendency of fully-insured individuals not to take proper precautionary measures to reduce risk, thereby making insurance coverage overly costly. Mechanisms used by insurance companies to fight the moral hazard problem typically involve copayments, deductibles and benefit caps, among others. An insurance plan with a higher level of copayments and deductibles achieves stronger cost-saving incentives at the expense of lower benefits from risk-sharing. Therefore, sensible insurance designs would balance risk-sharing benefits and moral hazard costs by setting the right levels of co-pays and deductibles.

As we will explain in this study, however, various government policies in this country regarding health insurance distort price signals, and either undermine the cost-saving mechanisms of private health insurance or fail to establish such mechanisms for public health insurance. As a result, health insurance in the U.S. is more than insurance. That is, our health insurance not only covers catastrophic risks, hence providing risk-reducing benefits, but also covers routine care and foreseeable expenses. This part of health 'insurance' is not insurance because it does not provide risk-reducing benefits but is better considered to be prepaid care.

Health insurance presents certain considerations that makes it a unique form of insurance. Individuals have different expected health care spending and are prone to different health risks. These risks change through time and are subject to large changes from abrupt health events. In an unregulated market, individuals who have known chronic conditions or who are expected to deal with a particular disease would pay higher premiums. We would end up with a spectrum of insurance premiums that are based on individuals' expected health care spending. However, those with the highest expected spending often have the lowest ability to pay, because their health conditions can interfere with steady employment and with investments in education and training that would lead to higher wages. If, on the other hand, insurers are not allowed to use the health-status information in determining insurance premiums, they assume that individuals who desire to purchase insurance might be doing so because they have an undisclosed health condition, resulting in the insurers charging premiums that take into account potentially higher costs. This so-called "adverse selection" problem contributes to higher insurance premiums and would lead some healthier individuals to go without insurance altogether.

Employer-provided health insurance (EPHI) has overcome some of these problems. By forming groups at the firm level, workers and their dependents, all with varying expected health care spending, are pooled together and pay similar insurance premiums.[6] But why do groups form at one's place of employment? The answer is the preferential tax treatment afforded health insurance when it is offered as part of a worker's compensation.

[6] Employer-based plans can include wellness incentive programs that lower enrollees' monthly premiums. They also have some flexibility to offer different plans based on location and category of employment. However, employers are subject to various HIPAA and Internal Revenue Code rules that address portability and nondiscrimination.

Every aspect of the provision of health care and its consumption is significantly affected by government policies. These policies determine how we pay for the health care we consume, be it through private or public health insurers. But one policy, the tax treatment of EPHI, has shaped all subsequent health policy decisions. The current tax treatment of excluding employer and employee contributions to an EPHI from a worker's taxable income began in the era of wage controls that were in effect during WWII. Employers were able to raise workers' compensation without raising wages by offering health insurance as a so-called fringe benefit. At the time, the IRS ruled that health insurance paid for by one's employer was not taxable income. We discuss how this tax treatment has expanded the scope of 'insurance' coverage to include routine care and has led to over-utilization of health care. Further, EPHI became the standard to which new public programs -- namely Medicare and Medicaid -- were compared. Consequently, these programs were also expected to offer similar comprehensive benefits.

This study addresses these problems in our health care system and shows how they often originate in ill-designed government policies towards health insurance. It argues that reforming the preferential tax treatment of employer-provided health insurance by replacing the existing tax exclusion with a system of refundable tax credits can serve as a centerpiece in reforming the overall health insurance market.

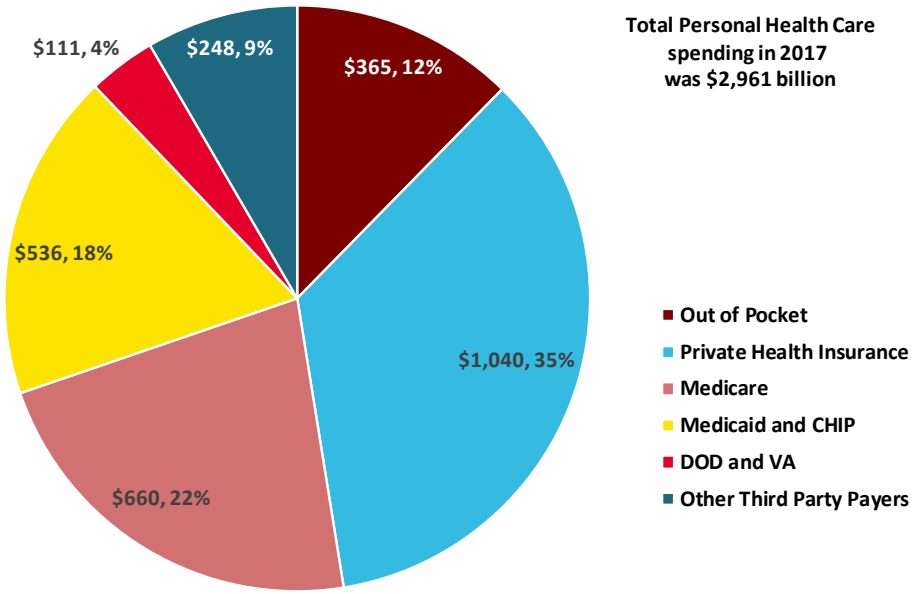
## THE PROBLEMS

### Paying for Health Care and the Unequal Distribution of Government Spending

Figure 1 depicts the distribution of personal health care spending in 2017 by source of payment. Public and private insurance paid for 79% of health care spending. Public insurance includes Medicare, Medicaid, and the Department of Defense and Veterans Affairs. Private insurance includes employer-based plans as well as privately purchased insurance through the exchanges established via the Affordable Care Act (ACA). Other third-party payers covered another 8% of spending and out-of-pocket spending accounted for 12%.

In many ways, the distinction between public and private payers has limited meaning. For example, about 25% of Medicare Parts B and D are financed through beneficiaries' premium payments, yet all Medicare payments are considered public. How is the funding of public health care spending distributed across taxpayers? To answer this, we have to consider the incidence of the payroll and income taxes that finance the public programs and the incidence of the forgone tax revenues associated with subsidizing private insurance. Additionally, to the degree that public programs contribute to deficit spending, the generational consequences of such financing must also be considered. Ultimately, all health care spending is paid for privately through premiums, out-of-pocket spending, or through the taxes on labor and on capital that fund public spending.

**Figure 1.** Distribution of Personal Health Care Spending by Payer in 2017
Billions




Source: National Health Expenditures, 1960-2017, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

While public payers account for almost half or all health care spending in the U.S., the federal government also foregoes tax revenues through the tax exclusion on EPHI. This tax exclusion is the driving force behind employers providing health insurance, and it results in a substantial loss of federal government tax revenue, an estimated $287 billion in 2019. That is, the 159 million people with EPHI would have paid just over $1,800 per person in additional taxes, on average, if EPHI was subject to federal income and payroll taxes.[7] Importantly, this tax exclusion is regressive, as it is a subsidy more valuable to those with higher incomes who are in higher marginal tax brackets.

Medicare and Medicaid enrollees receive the largest government subsidies. Those who purchase health insurance on the ACA's exchanges are also eligible for subsidies. The Congressional Budget Office (CBO) estimates that in 2019 the subsidies for insurance available on the exchanges and for the basic health program will total $62 billion.[8]

Over time, health insurance coverage, be it private or public, has become increasingly comprehensive. The comprehensive nature of EPHI is a by-product of its preferential tax treatment, and public programs and the insurance available on the exchanges are modeled after EPHI.

## High and Rising Health Insurance Premiums

Much of private health care spending takes the form of premium payments. An important part of spending control is to contain premium growth. However, insurance premiums have consistently

[7] "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2019 to 2029," Congressional Budget Office, May 2019.
[8] "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2019 to 2029," Congressional Budget Office, May 2019.

outpaced earnings growth. For example, the average annual premium for employer-based family coverage grew 25% between 2012 and 2018, compared to the 14% growth in average earnings for the same period. From 2017 to 2018 alone, premium growth was 5%.[9]

The premiums for insurance plans sold on the so-called "exchanges" are growing even faster.[10] The benchmark plan available through the federal exchange grew 85% from 2014 to 2019. Average annual individual insurance premiums for the benchmark plan on HealthCare.gov rose from $2,616 in 2014 to $4,860 in 2019.[11] Premiums on the federal exchange rose at varying annual rates. The highest annual increase was between 2017 to 2018 when premiums rose 37%. Between 2018 and 2019 they fell 2%.[12]

As a sign of further premium increases down the road, the incentive for insurance companies to participate in health insurance market places has been dwindling. In the states that use HealthCare.gov, the average number of insurers participating in the marketplace was 6 per state in 2015 and 2016, 4 in 2017, 3 in 2018, and back to 4 in 2019. In 2019, Alaska, Delaware, Mississippi, Nebraska, and Wyoming will each have only a single company offering plans.[13]

Rising health insurance premiums makes health insurance increasingly unaffordable, threatening the viability of this critical institution in health care provision.

### The Uninsured

The combined health care spending of all levels of government in the U.S. exceeded the health care spending of all other OECD governments except Norway and Switzerland in 2015.[14] Despite this, 28.5 million people in the U.S. did not have health insurance coverage in 2017. The uninsured generally receive less medical care and less timely care, have worse health outcomes, and are at higher risk of personal bankruptcy from medical bills. Although the social safety net is such that the uninsured still qualify for governmental financial assistance as needed, the uninsured who experience a large negative health event receive comparatively little help from the government.[15]

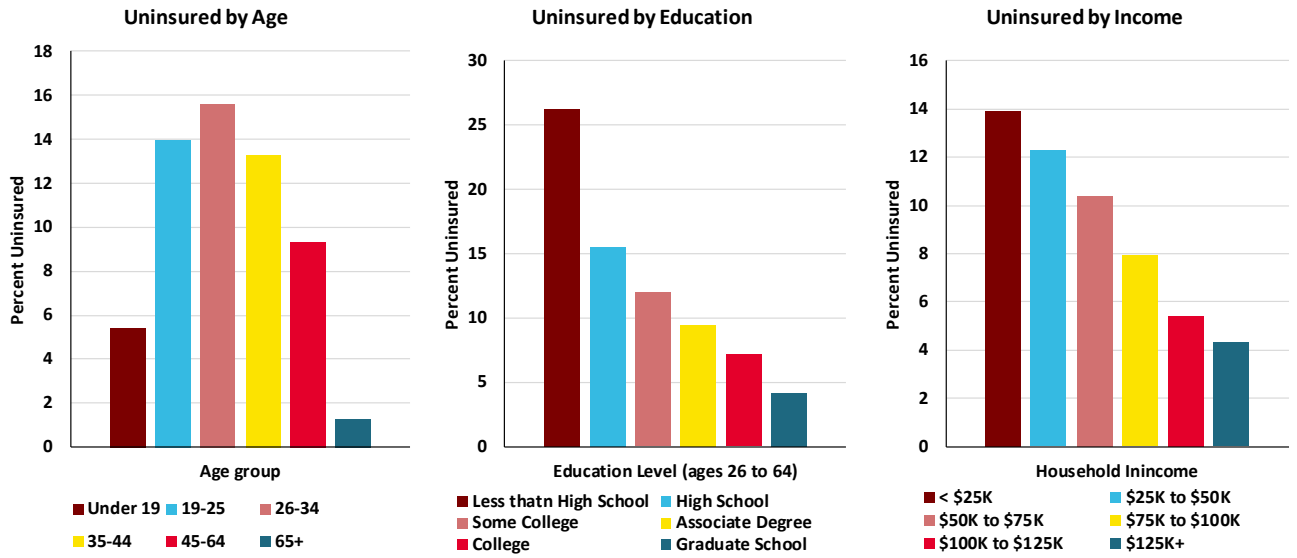
The ACA was intended, in part, to address the problem of the uninsured. While the number of uninsured fell after the enactment of the ACA, it never approached zero. Initially, the uninsured rate declined significantly from just below 16% in 2009 to 8.8% in 2017, with the sharpest decreases taking place from

[9] "Employer Health Benefits 2018 Annual Survey," The Henry J. Kaiser Family Foundation, 2018.
[10] A health insurance exchange is a place where people not covered by a government or group insurance plan can purchase health insurance coverage. These exchanges or market places were established as a result of the Affordable Care Act (ACA) of 2010. There are both state-based exchanges and the federal-facilitated exchange (HealthCare.gov). Whether one uses the Open Sans Open Sansfederal exchange, or a state exchange depends on the state in which one lives.
[11] "2019 Health Plan Choice and Premiums in HealthCare.gov States," *ASPE Research Brief*, October 26, 2018, Department of Health and Human Services. The benchmark plan as defined in this publication is the average premium of the second lowest cost silver plan available to a 27-year-old individual.
[12] See Table 3 in "2019 Health Plan Choice and Premiums in HealthCare.gov States," *ASPE Research Brief*, October 26, 2018, Department of Health and Human Services.
[13] "2019 Health Plan Choice and Premiums in HealthCare.gov States," *ASPE Research Brief*, October 26, 2018, Department of Health and Human Services, p.3.
[14] "Health Spending", in *Society at a Glance 2016: OECD Social Indicators*, OECD Publishing, Paris.
[15]Edward R. Berchick, Emily Hood, and Jessica C. Barnett, "Health Insurance Coverage in the United States: 2017", U.S. Census Bureau, September 2018.

2013 to 2014 (2.8 percentage points) and from 2014 to 2015 (2.3 percentage points).[16] These reductions can be attributed to the expansion of Medicaid eligibility and the establishment of the exchanges. However, there was no change in the uninsured rate from 2016 to 2017, and the momentum behind the falling rate of the uninsured has dissipated.

The uninsured are not a monolithic group. Some are wealthy but choose to self-insure. Among the poor, some are able but unwilling to spend their limited resources on health insurance. Others may be unable to afford health insurance. In a developed country with a comprehensive social safety net such as the U.S., the "uninsured" poor are not excluded from receiving health care services, although those services might be delivered inefficiently both in terms of costs and the health of the patient. The fact that society provides some level of health care for the "uninsured" gives some individuals the incentive to forego the purchase of health insurance and rely on this final backstop for emergency care.

**Figure 2.** Uninsured by Age, Education, and Income in 2017




Source: Edward R. Berchick, Emily Hood, and Jessica C. Barnett, "Health Insurance Coverage in the United States: 2017", U.S. Census Bureau, September 2018.

The uninsured rate is 8.8%, but differs by age, educational attainment and income, as shown in Figure 2. When considering age, the uninsured rate in 2017 was highest among those who were 26 to 34 years of age, at 15.6%. A majority of the uninsured, 51.5%, are 34 years of age or younger. The middle panel identifies the uninsured rate by education level among the adult population, those who were 26 to 64 years of age. The uninsured rate was highest for those with less than a high school education, at 26.3% who make up 20.5% of the uninsured adult population. About 56% of the adult population that is uninsured have a high school education or less, but 44% have some college or higher education. The uninsured rate is higher for lower income households. People living in households with incomes of less than $75,000 comprise 69% of the uninsured, but 31% are in households with incomes of $75,000 or higher. The uninsured rate among people living in households with an annual income of less than $25,000 was 13.9%. While only 4.3% of people in households with an annual income of more than $125,000 had no

[16] Edward R. Berchick, Emily Hood, and Jessica C. Barnett, "Health Insurance Coverage in the United States: 2017", U.S. Census Bureau, September 2018.

health insurance, they comprise 12.6% of the uninsured population. It is noteworthy that there are households with six-figure incomes that chose not to purchase health insurance.[17]

The CBO estimates that most of the uninsured in 2019 (68%) are either eligible for subsidized coverage through a marketplace (23%), eligible for Medicaid or CHIP (15%), or have access to insurance through an employer or directly from an insurer but chose not to purchase it (30%). The CBO notes that remaining uninsured either are not lawfully present in the U.S. (20%) or have income of less than 100% of the Federal poverty level and live in one of the non-expansion states (12%).[18]

## THE CAUSES OF THE PROBLEMS: ILL-DESIGNED GOVERNMENT POLICIES

In this section we discuss how the main problems surveyed above, including the unequal distribution in government health care spending, high and rising health insurance premiums, and the uninsured are all rooted in government policies. In particular, we will argue that the tax exclusion of employer-provided health insurance (EPHI) is related to some other health insurance policies that are responsible for the existing problems in the insurance market.

### Tax Exclusion on EPHI

Employer provided health 'insurance' in the U.S. is a combination of insurance and prepaid health care. Typically, insurance would not cover routine, expected expenditures.[19] Our health 'insurance' covers a large portion of expected health care expenditures because of the tax exclusion we allow for EPHI. Based on the tax law codified during WWII, both employer and employee contributions to the purchase of EPHI are excluded from an individual's taxable income. Without this subsidy, providers and purchasers of health insurance would have much less interest in buying insurance to cover routine care. In fact, doing so causes a "common resource" problem (a variant of the "moral hazard" problem) that leads to over-utilization of routine health care. Basically, all contributors would want to make sure they got back all or more of their individual contribution to the common pool of funds for routine care, and thus would have an incentive to overuse routine health care. The government tax subsidy creates these perverse incentives.[20] The tax exclusion distorts resource allocation in favor of routine health care relative to other consumption and is responsible for excessive health insurance premiums and overly comprehensive insurance plans.[21]

Since EPHI has become the "market standard" to which other public and private health insurance, including Medicare, Medicaid and insurance plans sold on the exchanges, are compared, the excessive EPHI plans have driven up the coverage scope and premiums for all other insurance plans. There is no

[17] Edward R. Berchick, Emily Hood, and Jessica C. Barnett, "Health Insurance Coverage in the United States: 2017", U.S. Census Bureau, September 2018.
[18] "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2019 to 2029," Congressional Budget Office, May 2019. See Figure 1-5.
[19] For example, home insurance does not include coverage for regular maintenance expenditures, because such coverage would not provide risk-reducing benefits.
[20] Note that the tax exclusion is credited for getting a majority of the under-65 population covered by health insurance, and for abating the "adverse selection" problem by encouraging the formation of employment-based insurance pools.
[21] Because the subsidy under the tax exclusion is tied to marginal tax rates, high income workers disproportionately benefit, making this a regressive subsidy.

doubt the existence of overly comprehensive EPHI plans in the "market" help provide a major rationale for various government mandates requiring insurance plans to cover many specific diseases and conditions. This in turn causes health insurance increasingly unaffordable to some individuals, contributing to the problem of the uninsured.

Because the subsidy implicit in the tax exclusion is tied to marginal tax rates, the tax exclusion benefits high-income workers more than low-income workers. Moreover, the tax exclusion discriminates against those self-employed or who are employed by firms that do not have health insurance as a fringe benefit.

### Lack of Cost-Saving Mechanisms in Private and Government Health Insurance

As discussed earlier, sensible health insurance designs would balance moral hazard costs and risk-sharing benefits by using various cost-saving mechanisms including copayments and deductibles. However, these cost-saving mechanisms are weak and even non-existent for some low-income individuals in government insurance (Medicare and Medicaid). In these cases, health care becomes essentially free, leading to overconsumption. And in the case of Medicare, most enrollees have Medigap policies that cover Medicare's deductible and copayments. These features are believed to have contributed to the high level of government spending on Medicare and Medicaid. For instance, the combined federal and state spending on Medicaid in 2017 was $582 billion, or $8,015 per person for the 72.6 million people enrolled in Medicaid. Average spending per enrollee in Medicare was $12,340. In contrast, the average spending was $6,001 per enrollee in private insurance.[22]

Moreover, cost-saving mechanisms built in private insurance may even be undermined by government policies towards health insurance. For example, those with private insurance can set up a flexible spending account (FSA) to help pay deductibles and other out-of-pocket expenses with pre-tax dollars. However, the FSA has a "use it or lose it" feature which encourages excess health care spending at year end as FSA participants use up the funds that would otherwise disappear from their account.

Although a health savings account (HSA) does not have this "use it or lose it" restriction, it is only available when paired with a high-deductible insurance plan. Therefore, in the current environment, the majority of the people who have employer-provided health insurance are not eligible for an HSA.

### Inefficient Government Mandates

Despite the considerable government spending and tax expenditures on health care, those who are not covered by any health insurance program remain vulnerable. These uninsured typically are not old enough to receive Medicare, are not poor enough to be eligible for Medicaid, and are not working for an employer offering EPHI. Depending on their income, they might or might not qualify for government assistance through the health care exchanges.

These individuals have decided that the price of health insurance is too high, and they opt to not purchase it. The availability of health insurance with lower premiums might change their mind, but government mandates regarding health insurance features (including prepaid care elements) preclude lower cost policies. While there may be strong reasons for certain mandates, such as the externality arguments for

[22]"Slow Growth in Medicare and Medicaid Spending per Enrollee Has Implications for Policy Debates," John Holahan and Stacey McMorrow, Urban Institute, February 2019.

vaccination against certain communicable diseases, such arguments do not support the large number of mandated coverages in health insurance. These mandated coverages must be paid for by premiums, and purchasers are unable to opt out of paying for undesired features by purchasing less comprehensive policies.

### Lack of Price Transparency and Provider Competition

The price of a specific procedure or therapy can be very different from one provider to another, and from one patient to another, depending on the deal struck between the health care provider and the patient's specific insurance program. Moreover, prices are seldom posted in any obvious manner – there is no 'menu' – and as anyone receiving treatment in a hospital can attest, there are procedures that generate bills from multiple different providers weeks after services are rendered. No one can shop by price when prices are revealed *after* services are tendered. The lack of pricing transparency renders it almost impossible for patients to make informed treatment decisions based on comparison shopping. The consequence is that both sides of the market have little reason to care about lowering the costs of health care.

## A REFORM OUTLINE

### Replacing the Tax Exclusion on EPHI with Lump-Sum Tax Credits

The problems associated with the tax exclusion on EPHI premiums can be alleviated by replacing the tax exclusion with refundable tax credits the size of which should depend on family characteristics (e.g. family size, the age of family members, as well as location) but not on the level of premiums paid.[23] The base tax credit amount would be sufficient to cover the purchase of a high deductible policy.

Obtaining a tax credit would hinge on buying insurance coverage, in order to maintain the incentives to buy health insurance. Workers would continue to purchase insurance through their employer. The incentives for low income workers to purchase health insurance would be much stronger under the system of tax credits because they would receive the same amount of tax credit as their comparable high-income counterparts. In contrast, under current rules workers with very low income receive little subsidy from the current tax exclusion.

While the amount of the tax credits for the purchase of health insurance would consider only family size, family members' ages and their location, the funding of the HSA to which the insurance policy is paired would also take into account family income. Currently HSAs are funded by with pre-tax contributions from the individual or family and these funds can be used to cover out-of-pocket health spending including the amount below the deductible. Funds remaining at the end of the year can be rolled over to the next year or used for other consumption after paying taxes and a penalty. In the new environment, however, the degree to which contributions to HSAs receive a tax-preference would be inversely related to family income.

[23] These are the same characteristics used in pricing health insurance on the health insurance exchanges. Health status is not included in pricing the insurance and insurers cannot exclude on preexisting conditions. In contrast, the payments Medicare makes on behalf of Medicare beneficiaries to Medicare Advantage plans are age, location, and risk adjusted. These payments to Medicare Advantage plans are essentially health insurance vouchers adjusted by a beneficiary's specific situation.

For low-income families, their own contributions would be made with pre-tax dollars, and the federal government would deposit additional means-tested contributions in their HSAs. Qualified withdrawals would not be taxed. Withdrawals for non-medical spending would be subject to the families' marginal tax rate and they would also face a penalty that is directly related to the share of the HSA contributions that were made by the government.

This incremental reform would generate efficiency gains by eliminating the distortion in the price of health insurance relative to other consumption.[24] Because the size of the tax credit is unrelated to the level of one's premium payment, the system of tax credits does not favor more comprehensive insurance policies, thereby helping lower insurance premiums.[25]

### HSAs to Strengthen Cost-Saving Incentives in Government Financed or Subsidized Health Programs

HSAs should be used to introduce or strengthen the mechanisms of copayments and deductibles in government-financed or subsidized programs such as Medicaid and the insurance plans offered on the exchanges. This can be done by depositing funds in an HSA for poor or disadvantaged individuals, but then requiring Medicaid enrollees and others to pay copayments and to be responsible for deductibles. Some predetermined percentage of unspent HSA deposits could be used by the enrollee at the end of the year for other consumption. The percentage that can be withdrawn could be tied to participation in wellness programs. The HSAs would increase consumers' direct role in financing the care they receive by bringing more market forces to bear on limiting growth in health care spending, mitigating the perverse incentives due to the first-dollar coverage.

Given the comprehensive social safety net in the U.S., and especially when many emergency rooms are required to treat patients regardless of ability to pay, it is probably true that some individuals will continue to under-purchase health insurance absent a subsidy. Some form of financial incentive will be needed to get all of the currently uninsured to purchase health insurance. Offering the currently uninsured a refundable lump-sum tax credit to purchase high deductible health insurance coupled with an HSA funded with means-tested contributions is an avenue for further expanding health insurance coverage, while infusing greater consumer control over health care spending.

### Keeping Government Mandates in Check

Over the years, the number of government mandates in the health insurance market has grown tremendously. As mentioned above, government mandates cause cost increases, and make it harder to get the uninsured to purchase insurance. The main point to keep in mind is that mandated benefits are

[24] The efficiency gain is estimated to be 21.3% of the annual tax expenditure on EPHI. See Liqun Liu, Andrew J. Rettenmaier and Thomas R. Saving, "The Welfare Gain from Replacing the Health Insurance Tax Exclusion with Lump-Sum Tax Credits," *International Journal of Health Care Finance and Economics*, 11 (2011) 101-113.

[25] It is estimated that a reform that replaces tax exclusion with lump-sum tax credits would reduce the level of insurance premiums by 76.6%. See Liqun Liu, Andrew J. Rettenmaier and Thomas R. Saving, "The Welfare Gain from Replacing the Health Insurance Tax Exclusion with Lump-Sum Tax Credits," *International Journal of Health Care Finance and Economics*, 11 (2011) 101-113.

not free, and it may be more efficient to pay for some of these benefits out of pocket rather than as a prepaid component in health insurance.

We should allow coexistence of and competition among insurance packages of various degrees of comprehensiveness. In particular, we should allow and even encourage the bare-bones catastrophic health insurance, both to reduce the number of uninsured and to reduce the prepaid component in health insurance in general.

### Ensuring Pricing Transparency and Making Providers/Patients Cost-Conscious

Shopping by price will enhance competition and add incentives for providers to actually innovate in the provision of health care services in ways that lower costs. The first step toward making patients and providers cost-conscious is to make price signals transparent and undistorted.

On June 24, 2019, President Trump signed an executive order on health care price and quality transparency which directs federal agencies to adopt rules and guidance to compel providers and insurers in the health-care industry to disclose price and quality information.

While this executive order is a necessary first step, the order by itself is not sufficient to ensure beneficial changes in the health care system. For example, prices of health services mean little to patients whose out-of-pocket costs are close to zero or for whom the any additional costs are zero. Prices also mean little to patients when bills are received long after the delivery of services, and when prices bear little relation to what patients actually pay. Providers and insurers must have a profit motivation to compete for customers using price and quality signals, and patients must have an incentive to actually seek out and utilize the price information. Together this would provide the force of competition to drive costs down.

Health care billing is currently not transparent or well understood by the consumer. For instance, health care bills for imaging and lab work often contain bills for the imaging, and separate bills for doctors examining/interpreting the images. These bills arrive separately and are paid separately. Hospital stays are even worse, with any number of bills for separate services, separate lab work, and separate providers. Imagine going to a restaurant, ordering from a menu without prices, and then receiving separate bills weeks later from the cook and the waiter. That is the analogy to our health care billing system. We should insist that prices be set and announced in advance for the bundle of services that accompany a procedure, thereby giving patients the ability to make informed decisions in a price-transparent world.

An obvious reform to encourage competition among providers is to increase the number of providers by reducing anticompetitive barriers, such as overly stringent scope-of-practice limits on nurse practitioners and physician assistants, as well as limits imposed by medical schools and medical societies on the supplies of doctors and specialists.

## CONCLUSION

It has now been almost a decade since the passage of the Affordable Care Act, and health care reform remains front and center in the lead up to the 2020 presidential election. As we have seen, over the years the issues remain the same in the health care debate. The debate continues to focus on the distributional

burden of who funds health care, on the distribution of the benefits across recipients of health care services, on how to address the lingering share of the population that remains uninsured, and on the best way to address the growth in health care spending.

This study focuses on the existing problems in our health insurance market including high and rising health insurance premiums, a large group of uninsured citizens, and a fair bit of inequality in the delivery of health care. It argues that some ill-designed government policies towards health insurance are actually responsible for these problems. This study offers an outline of efficiency-enhancing reform, including replacing the tax exclusion on employer-provided health insurance with tax credits, using the health saving account to strengthen cost-saving incentives, keeping government mandates in check, and ensuring pricing transparency to better achieve greater cost-consciousness among both providers and patients.

The centerpiece of the health insurance reform suggested in this study is exchanging the open-ended tax exclusion on employer-provided health insurance with a tax credit sufficient to cover the expense of high deductible health insurance. It is also suggested that the high deductible insurance be paired with a health savings account to help pay for out-of-pocket costs. This reform would eliminate the distortion created by the tax exclusion that makes the price of health insurance (prepaid health care in particular) artificially low relative to the price of other consumption. It would also make consumers more cost-conscious on the first dollars they spend on health care and could lower health care spending and potentially the growth rate in spending. The reformed private sector health insurance would have repercussions across the health care sector because employer-provided health insurance is the benchmark to which all other health insurance is compared.