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BASIC ELEMENTS OF FINANCING NATIONAL HEALTH INSURANCE,(U)

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# BASIC ELEMENTS OF FINANCING NATIONAL HEALTH INSURANCE

10 Bridger M. Mitchell

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## PREFACE

During February, 1976 the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, U. S. House of Representatives held a series of hearings on the subject of national health insurance. On February 25 a panel of witnesses addressed the topic of Budget and Financing Issues. The members of the panel were:

The Honorable Brock Adams, Chairman, House Committee on the Budget

Dr. Alice Rivlin, Director, Congresional Budget Office

Dr. Bridger M. Mitchell, The Rand Corporation

Dr. Stuart H. Altman, Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education and Welfare

This paper consists of Dr. Mitchell's statement to the Subcommittee.

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## SUMMARY

The basic policy issue to be resolved in choosing how to finance a national health insurance program is to decide how the total costs of health care will be distributed. Revenues sufficient to fund the program can be raised by prepayments, in the form of premiums and taxes, and by out-of-pocket payments made by patients. The principal factors that determine the distribution of total costs by income group are the extent to which payroll and income taxes, in contrast to premiums, are relied on to finance the prepaid component of total costs.

The financing provisions of any bill can be analyzed to determine the costs that it would impose on taxpayers at each level of income. In similar fashion, economic analysis can be used to design new combinations of premiums, taxes and out-of-pocket payments that will distribute the costs of a national plan according to a pattern specified by policymakers.

Federal tax laws currently exclude most health insurance premiums and medical expenses from taxation, a practice that produced an $8 billion loss of federal revenues in 1975. These tax savings or indirect subsidies flow disproportionately to upper income taxpayers. The enactment of a national health insurance program funded by mandatory employer premiums could reduce tax revenues by an additional $6 billion. If, however, the tax exemption for health insurance premiums were eliminated, additional federal revenues would be available to fund the public portion of a national program.

The United States now has a small-scale plan of national health insurance through the personal income tax deduction for medical expenses. If the law were changed from a deduction to a tax credit, greater benefits

would be directed to taxpayers with lower incomes. Similar modifications could convert the medical deduction into a national plan of catastrophic insurance.

# BASIC ELEMENTS OF FINANCING NATIONAL HEALTH INSURANCE*

Bridger M. Mitchell

Mr. Chairman and Members of the Committee: I wish to thank you for the opportunity to participate in this session of your hearings on national health insurance and to address some of the budgetary and financing issues that face the country in establishing a program of national insurance.

For the last three years I have been engaged in research on the economic implications of financing a program of national health insurance in the United States and on incentives in current tax laws that encourage the purchase of both health insurance and medical services. Much of this work has been conducted in collaboration with Dr. Ronald J. Vogel of the Social Security Administration, Dr. Charles E. Phelps of Rand, and Dr. William B. Schwartz of Tufts University. In my remarks today, I will focus chiefly on the basic economic principles that underlie the financing of a program of national insurance and will draw on our research findings to illustrate these principles.

There are a host of economic issues that must be confronted in establishing any plan of national health insurance--issues such as control of the cost of medical care, incentives to provide services of appropriate quality, the extent of financial risk to be borne by patients, and the

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*Testimony prepared for Subcommittee on Health and the Environment, U.S. House of Representatives Committee on Interstate and Foreign Commerce.

**The first sections of my testimony draw extensively on unpublished results from research that Dr. Schwartz and I have been conducting. I would especially like to acknowledge his contribution to the preparation of these remarks.

allocation of national resources to health care at the expense of other uses. However, today I wish to focus squarely on the issues involved in *financing* a national plan. In this context, the fundamental policy question is simply posed: how shall the costs of a national health insurance program be shared? I will first examine how the principal financing provisions of any health insurance plan determine the distribution of costs to taxpayers at different levels of income and then consider the effects of our existing tax laws on health insurance and medical care expenses.

The total costs of a national plan will be determined by the plan's provisions for eligibility, benefits, and administration. In practice, it is necessary to estimate total costs by extrapolating historical data to new circumstances, a difficult and uncertain process. However, for our purposes today it is necessary only that there be a total cost value.

To illustrate the major principles of financing national health insurance I will employ a simple numerical example and assume that the total costs of a hypothetical national plan are $60 billion per year for the U.S. population under age 65. This expenditure, in fact, corresponds roughly to the costs of a number of national health insurance bills. However, none of the examples I will present represents the costs of any actual legislative proposal; I have deliberately simplified the details of each type of health insurance bill in order to highlight the key financing decisions that must be made in funding any new insurance plan.*

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*A more extensive analysis of four prototypical national health insurance bills is contained in Bridger M. Mitchell and William B. Schwartz, "The Financing of National Health Insurance," *Science*, forthcoming.

The total costs of $60 billion can be raised by (a) out-of-pocket payments by patients at the time they use medical care, (b) by prepayments, in the form of premiums and taxes, or (c) a combination of both out-of-pocket payments and prepayments. For this example, I will assume that of the total costs, $50 billion will be collected in the form of premiums or taxes to pay for the health care expenses reimbursed under the plan, and that the remaining $10 billion of total costs will be collected from patients in the form of deductible and coinsurance payments.

The Incidence of Premiums and Taxes

There are three basic sources of revenue available to finance the $50 billion portion of total costs--premiums, payroll taxes and general revenues. Each imposes a different pattern of costs on taxpayers at various income levels.

*Premiums* are conventionally set at two levels, one value for family coverage, and a lower amount (between 33% and 40% of the family premium) for coverage of single individuals. For convenience, I will refer primarily to the effect on families, and will make all calculations for the fiscal year 1975. There are about 49 million families and 25 million single individuals in the U.S. under the age of 65. If each family were to pay a premium of $850 per year and each single person $340, the total revenue would just equal $50 billion.

Note that this calculation provides us with the amount of revenue available to pay for benefits and for administration of the program--an average of $850 per family for a $50 billion plan. Of course, the actual benefits received by any one family in a given year will depend on the amount and severity of its illnesses, its size and propensity to use medical care, and similar factors. Nevertheless, I will make the simplifying assumption that, at least approximately, families

receive the same *average* value of benefits regardless of their level of income. In this case, the family premium measures not only a family's advance payments for health care, but also the benefits (including administrative costs) that it can anticipate from a national plan. This dual role of the premium value is illustrated in Figure 1 in which the straight line at the value of $850 is labelled both "premium" and "anticipated benefits." If we like, we may think of a separate insurance program at each income level; each program collects a certain amount of revenue from all taxpayers at the given level of income and, after allowing for costs of administration, pays out all of the remaining funds for their medical expenses.

*A payroll tax* is collected as a constant percentage of earnings until an upper limit is reached, after which no further tax is levied. The total revenue that will be raised by a particular payroll tax can be readily calculated once the number of taxpayers at each level of earnings is known. Under a national plan that covered all employees and dependents under age 65, it would require a payroll tax rate of 6.9% on earnings up to the present earnings limit of $15,300 to raise $50 billion.

A family with an income of about $13,000 would pay as much in payroll taxes, $850 per year, as it would pay under a premium program. Therefore, at this level of income a family's tax payments are equal to its anticipated benefits.*

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*This "break-even" level of income is actually slightly higher than the level that would be calculated if all income were taxable, because the average family at this income level earns roughly 3% of its income from sources such as interest on savings account deposits that are not covered by a payroll tax.

Figure 1

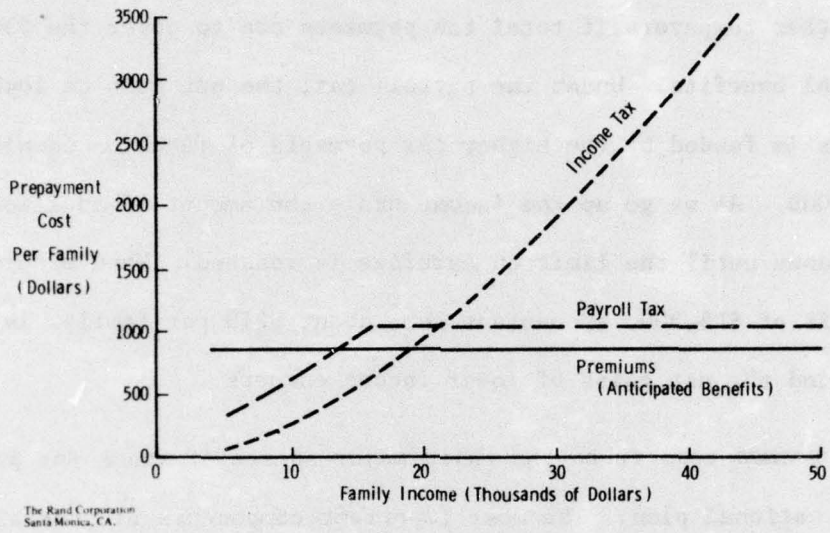



Table 1

Distribution of Prepayment Costs

| Family Income | If Plan is Financed by a: | | |
|---|---|---|---|
| | Premium | Payroll Tax | Income Tax |
| $ 3,000 | $850 | $ 210 | $ 0 |
| 6,000 | 850 | 400 | 100 |
| 9,000 | 850 | 610 | 260 |
| 12,000 | 850 | 780 | 400 |
| 15,000 | 850 | 970 | 560 |
| 20,000 | 850 | 1,060 | 930 |
| 30,000 | 850 | 1,060 | 1,910 |
| 40,000 | 850 | 1,060 | 3,080 |
| 50,000 | 850 | 1,060 | 4,330 |

Families with incomes less than $13,000 make smaller tax payments but receive the same benefits and thus enjoy a net gain from the national health insurance plan. This reduction in revenue must, of course, be made up from other taxpayers if total tax payments are to cover the $50 billion in total benefits. Under the payroll tax, the net gain of lower income families is funded by the higher tax payments of families earning more than $13,000. As we go up the income scale the amount of additional taxation increases until the limit on earnings is reached. When earnings exceed the limit of $15,300, a constant sum, about $210 per family, is collected to fund the net gains of lower income earners.

*General revenues* constitute the third major source of funds for prepaid financing of a national plan. The most important components of general revenues are personal and corporate income taxes. Because a major program such as national health insurance would, if financed from general revenues, rely primarily on increases in the rates at which personal incomes and corporate profits are taxed, I will refer to this source of funds simply as the *"income tax"*.

To calculate the burden of the income tax I assume that each individual and business taxpayer's tax payments would be increased by an equal percentage amount. This is equivalent to using a simple surtax to raise the required revenues. Of course, the Congress could revise the income tax laws at the time it enacted national health insurance in order to raise more revenue from some groups of taxpayers and less from others. However, the national health insurance bills that have been introduced specify only "general revenues," and in the absence of special legislation to revise tax rates, the calculations made here provide a sound basis for assessing the tax burden of general revenue funding of a national plan.

To raise $50 billion would require that personal and corporate income tax rates be increased 28%. The burden of these added taxes is shown in the final column of Table 1 and graphically as the line labelled "income tax" in Figure 1. At an income of about $19,000 the average family would pay $850 and thus be in a "break-even" position, anticipating an equal amount of benefits from the insurance program. Below the $19,000 income level families would pay lower taxes and be net gainers. Both the figure and table make clear that these families pay lower taxes and therefore obtain greater gains than they would enjoy under a payroll tax program. Of course, these gains are only possible because of higher tax payments by more affluent taxpayers. Since the amount of income tax rises indefinitely with higher income, the amount that is transferred from a higher income taxpayer is larger the greater is his income.

Employer Premiums and Payroll Taxes

Despite the fact that many bills specify that a portion of the premiums or payroll taxes are to be paid by employers on behalf of their workers and their families, I have not distinguished between payments and premiums made by wage-earners from those made by their employers, and have calculated the burden of a premium or payroll tax as if the employee made all of the payments. This calculation rests on the important economic fact that for most workers increases in employer-paid taxes on labor occur at the expense of higher wages. In competing to produce their products at lowest cost (or greatest profit), business pay employees according to their productivity. If, as the result of a new national health insurance program, employers are

required to pay additional taxes or premiums in order to hire each worker, they will attempt to reduce take-home wages (or fringe benefits) in order to keep total labor costs from rising.

Since collective bargaining contracts and other institutional factors limit the ability of employers to change wages at once, some time may pass before the employer's share of a premium or payroll tax is fully passed on to his workers. In a period of general inflation, this adjustment can occur with no reduction in the dollar amount of wages. By simply failing to raise wages as rapidly as prices are increasing, the employer may reduce his real labor costs and shift his health insurance payments to workers.

There is one important qualification to the general conclusion that employer premiums and payroll taxes are, in the long run, passed on to employees. Workers who are employed at the minimum hourly wage cannot legally have their wages reduced. Unless the process of inflation permits real wages to fall, firms will reduce their employment of low-wage workers and substitute for them more mechanized and relatively cheaper methods of production. As a result, although the financial burden will not be as great for such workers as shown in my calculations, requiring employers to pay premiums or payroll taxes can be expected to reduce employment among workers at the lowest income levels.

Combinations of Taxes

Until now, I have considered the "pure culture" cases in which the entire amount of prepaid revenue is raised from a single source--a premium, a payroll tax or an income tax. In fact, an actual national health insurance program is likely to utilize a mixture of two, or even three of these sources of revenue, if only because the existing Medicaid and disability health insurance programs would be continued in revised form.

Most national health insurance proposals that have been introduced in the Congress rely on either the premium or the payroll tax as the principal source of revenue and use the income tax for the remainder of the needed funds. In these bills premiums or payroll taxes generally account for from one-half to three-quarters of the total revenue. To illustrate how a mixture of revenue sources alters the burden for different taxpayers, consider a $50 billion program that relies on a premium for two-thirds of its revenue, or $33 billion, and obtains the balance from income taxes. The tax burden at any income level will now be intermediate between the pure premium and pure income tax cases shown in Figure 1. As shown in the second figure and table, gains accrue to families below about $20,000 income, but they are considerably smaller than those under a pure income tax program. The transfers from higher income families are similarly less extreme when mixed financing is used.

By way of comparison, consider a second $50 billion program that utilizes a payroll tax, rather than a premium, for two-thirds of its revenue and again uses the income tax for the balance. The incidence of this mixture of taxes bears some resemblance to that of the premium-income tax combination. Thus, from Figure 2 and Table 2 we can see that middle and upper income taxpayers have a somewhat similar tax burden under both programs. Although the payroll tax-income tax plan is more costly to families above the $13,000 level of income than is the premium-income tax plan, the difference remains roughly constant, about $140 per family. These added payments under the payroll tax-income tax plan make up for the reduced amount of revenue collected by a payroll tax from lower income taxpayers. At lower incomes the two tax mixture plans are less similar. While the payroll tax-income tax program reduces tax payments to less than $140 below an income level of $3,000, the corresponding payments are $570 under the premium-income tax plan.

Figure 2

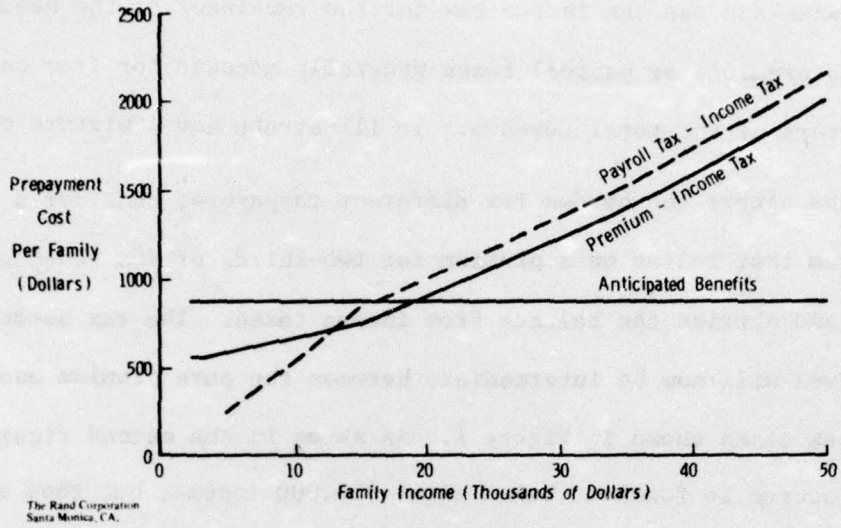



Table 2

Distribution of Prepayment Costs

| Family Income | If Plan is Financed by a 67%/33% Combination of | |
|---|---|---|
| | Premiums and Income Tax | Payroll Tax and Income Tax |
| $ 3,000 | $ 570 | $ 140 |
| 6,000 | 600 | 300 |
| 9,000 | 650 | 490 |
| 12,000 | 700 | 650 |
| 15,000 | 760 | 840 |
| 20,000 | 880 | 1,020 |
| 30,000 | 1,200 | 1,340 |
| 40,000 | 1,590 | 1,730 |
| 50,000 | 2,010 | 2,150 |

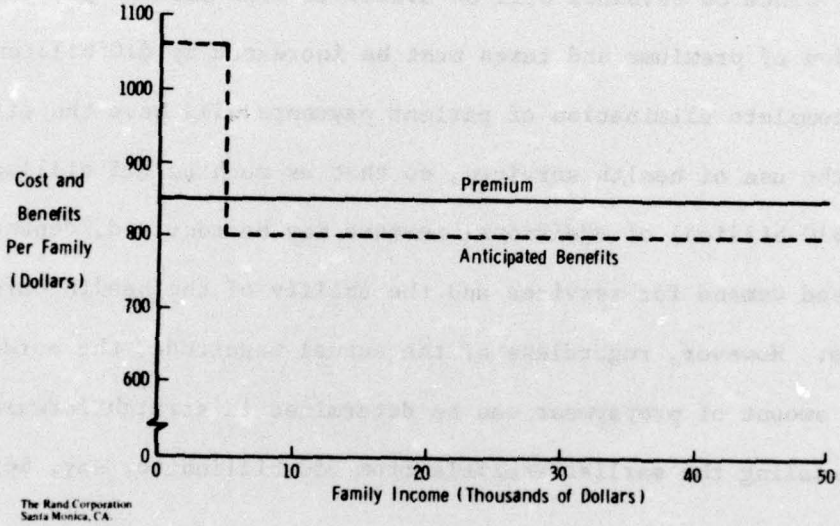
Variable Cost Sharing

In each of these examples I have assumed that all families covered by the national health insurance plan were required to make the same out-of-pocket payments to obtain medical services, and that in the aggregate such payments totalled $10 billion. If these payments are reduced or eliminated, the analysis must be modified accordingly.

Elimination of all out-of-pocket payments is readily dealt with. In this instance, since no revenues will be available from patient payments, some combination of premiums and taxes must be increased by $10 billion. In fact, the complete elimination of patient payments will have the effect of expanding the use of health services, so that as much as $15 billion (rather than $10 billion) of additional revenue may be required, depending on the increased demand for services and the ability of the health care system to supply them. However, regardless of the actual magnitude, the burden of the increased amount of prepayment can be determined in straightforward fashion by rescaling the earlier analysis from $50 billion to, say, $65 billion.

Many national health insurance plans specify that cost-sharing shall be reduced or eliminated for only selected families, usually those with lower incomes. To examine the effect of variable cost-sharing, I will return to the example of the hypothetical national plan under which all families anticipated the same average level of benefits, shown again in Figure 3. If we now eliminate all out-of-pocket payments for families with less than $6000 of income, the average benefits of each such family will be increased by approximately $210. To pay for these added benefits the plan must either increase taxes, or reduce benefits for other taxpayers. Suppose that the level of taxes remains unchanged and that increased out-of-pocket payments are

Figure 3


1100
1000
900
800
700
600
0
Cost and
Benefits
Per Family
(Dollars)
Premium
Anticipated Benefits
0
10
20
30
40
50
Family Income (Thousands of Dollars)
The Rand Corporation
Santa Monica, CA.

required of families with incomes above $6000. Since there are about four times as many families with incomes above $6000 as there are below that level, the benefits of the larger group of taxpayers would have to be reduced about $50 each to provide the necessary funds.

Net Benefits and Redistribution of Income

As we have seen, plans for financing national health insurance generally impose costs in the form of premium and tax payments that vary according to the level of income. In addition, some plans also vary the cost-sharing and thus the benefits of the plan. The financial effects for different families can be summarized by the *net benefits* at each level of family income. The net benefits of a national health insurance plan can be defined as the difference between the value of the health services that a family anticipates using and the amount of premiums, taxes and out-of-pocket expenses it expects to pay.

All of the plans we have analyzed produce positive net benefits, or net gains, for lower-income families and net losses at higher levels of income. In this sense national health insurance serves to redistribute income from more affluent taxpayers to those with limited means. To illustrate this point, I have combined two of the examples considered earlier, taking the premium-income tax combination and adding to it the variable cost-sharing plan that eliminates out-of-pocket payments for families below $6000 income. As shown in Table 3, this program produces a significant redistribution from upper to lower income taxpayers and sizeable net benefits at lower income levels; net benefits are $490 at an income of $3000, $460 at an income of $6000 and $150 an income of $9000.

We may conclude from this analysis that there are as many ways of distributing the costs of a national plan as there are different combination

Table 3

Payments and Net Benefits Under a Plan Financed by
67% Premiums, 33% Income Tax and Variable Cost Sharing

| Family Income | Value of Health Services Used | Premium | Income Tax | Out-of-Pocket | Total Payments | Net Benefits |
|---|---|---|---|---|---|---|
| $ 3,000 | $ 1,060 | $ 570 | $ 0 | $ 0 | $ 570 | $ 490 |
| 6,000 | 1,060 | 570 | 30 | 0 | 600 | 460 |
| 9,000 | 1,060 | 570 | 80 | 260 | 910 | 150 |
| 12,000 | 1,060 | 570 | 130 | 260 | 960 | 100 |
| 15,000 | 1,060 | 570 | 190 | 260 | 1,020 | 40 |
| 20,000 | 1,060 | 570 | 310 | 260 | 1,140 | -80 |
| 30,000 | 1,060 | 570 | 630 | 260 | 1,460 | -400 |
| 40,000 | 1,060 | 570 | 1,020 | 260 | 1,850 | -790 |
| 50,000 | 1,060 | 570 | 1,440 | 260 | 2,270 | -1,210 |

of premiums, taxes and out-of-pocket payments. To make the point most clearly I have abstracted from the particulars of actual legislative proposals. For example, imposing patient payments abruptly at a single level of income (e.g., $6000) is undesirable because workers near this income level who might otherwise increase their earnings are deterred from doing so by the sharp reduction in health benefits that would result. To cope with this difficulty many bills with cost-sharing requirements gradually increase the required amount of out-of-pocket payments as the level of income rises. I have also overlooked the differences between families and single individuals, the age and healthiness of different population groups, and the possibility that one income group will use more medical care than another. Nevertheless, although the inclusion of these factors would quite properly qualify the conclusions and make the details of the analysis more accurate, the major result would be unchanged. An economic analysis of the financing provisions of any proposed national health insurance plan can determine the cost burden and net benefits of each group of taxpayers.

It is less apparent, but of at least equal importance, that this analytic process can be reversed. Consequently, within broad ranges the policymaker can specify in advance what distribution of the total costs of a plan he wishes to achieve and then determine the combination of premiums, payroll and income taxes , and cost-sharing that will produce the desired distribution. With this tool at his disposal, the sponsor of a bill can have confidence that the financing provisions he includes in his program will have the intended consequences.

Tax Expenditures for Health Insurance and Medical Expenses

Until now, my discussion of alternative methods of financing national health insurance has ignored the fact that the Federal government indirectly spends some $8 billion on a national program of assistance for medical expenses. These expenditures take the form of tax exemptions for health insurance premiums purchased by employers as well as tax deductions for premiums and out-of-pocket medical expenses paid by individuals.

For many years Federal income tax laws have encouraged employers to provide health insurance coverage to their employees, allowing them to deduct the costs of insurance policies as a business expense in calculating their income tax liabilities. At the same time, such benefits are not included in calculating the income of employees that is subject to social security and personal income taxes. The tax laws thus establish employer-paid insurance premiums as tax-exempt income.

I have estimated that in 1975 health insurance premiums paid by employers averaged $378 for a worker and any dependents.* If these benefits had not been exempt from taxes, the average worker and his family would have paid additional federal income and social security taxes of $122. This indirect subsidy of health insurance thus amounts to nearly one-third of the premium costs.

The value of this tax exemption to an employee depends both on the size of his employer's payment and on the rate at which the employee's regular income is taxed. As can be seen from Table 4, employer contributions for health insurance are about twice as large ($436) for high income workers as they are

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*Mitchell, Bridger M. and Charles E. Phelps, "Employer-Paid Group Health Insurance and the Costs of Mandated National Coverage," The Rand Corporation, R-1509-NC/OEO, August 1975.

Table 4

Distribution of Employer-Paid Health Insurance Premiums and Indirect Tax Subsidies, 1975

| Income of Taxpayer ($) | Employer Premiums Per Insured Taxpayer | Average Marginal Tax Rate | Subsidy per Insured Tax-Payer |
|---|---|---|---|
| All Tax Payers | $ 378 | 31.8% | $ 122 |
| 0 - 3,000 | 219 | 22.7 | 48 |
| 3,000 - 5,000 | .204 | 29.0 | 60 |
| 5,000 - 7,000 | 214 | 31.5 | 68 |
| 7,000 - 10,000 | 266 | 31.7 | 84 |
| 10,000 - 15,000 | 433 | 31.4 | 137 |
| 15,000 - -20,000 | 406 | 30.6 | 124 |
| 20,000 - -50,000 | 436 | 34.1 | 151 |

Source: Mitchell, Bridger M. and Charles E. Phelps, "Employer-Paid Group Health Insurance and the Costs of Mandated National Coverage," The Rand Corporation, R-1509-NC/OEO, August 1975.

for employees at the lowest incomes ($219). When the effect of rising tax rates is taken into account, the indirect tax subsidy for health insurance increases from about $50 per taxpayer at the lowest income to more than $150 at higher levels.

In aggregate terms, the amount of these indirect subsidies or tax expenditures for employer-paid health insurance is substantial. I estimate that in 1975 about $5.5 billion in federal revenues were not collected as a result of the exemption of employer premiums from taxation.

If a national health insurance plan were financed by mandating that all employers offer a standard package of insurance benefits to their workers, the amount of these tax expenditures would increase significantly. For example, *a plan with quite comprehensive benefits and a requirement that employers pay 75% of the premium would cause a federal revenue loss of an additional $6 billion.* Conversely, if the tax-exemption for health insurance premiums were eliminated, additional revenues would become available in the federal budget, funds that could be used to finance the public portion of a national program. Particularly if the national plan required universal participation by employers, there would be little need to continue exempting premiums from taxation in order to encourage the purchase of health insurance coverage.

It is not often recalled that the United States has for many years operated a small national plan of health insurance. The program in question is the medical deduction in the personal income tax, which I have referred to as the IRS Plan.* Under the medical deduction every taxpayer is covered

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*Mitchell, Bridger M. and Ronald J. Vogel, "Health and Taxes: An Assessment of the Medical Deduction," *Southern Economic Journal*, April 1975.

for an extremely comprehensive range of services, including, for example, the costs of transportation to the doctor's office. In addition, the medical deduction allows taxpayers to itemize up to one-half of their health insurance premiums not paid for by employers. In 1975, the total tax expenditures resulting from the IRS plan amounted to at least $2.5 billion.

The cost-sharing requirements of the IRS plan are rather unusual, in that both the deductible and the coinsurance rate depend on the taxpayer's income. Under the medical deduction, medical expenses incurred by the taxpayer receive no tax benefit until they exceed 3 percent of his income. (In addition, drug expenses are subject to a separate 1 percent of income limit.) Thus the deductible feature of the IRS plan is directly proportional to income.

Medical expenses that exceed the amount of the deductible may be subtracted from taxable income and therefore result in some savings to the taxpayer. For each dollar of additional medical expense, the savings depend on the rate at which the last dollar of income is taxed. Since the rate of taxation increases with higher income, low income taxpayers receive little reimbursement from the IRS plan and must pay for a high proportion of their added medical spending out of pocket, whereas, individuals in higher tax brackets have a greater proportion of their additional spending shared by the government. As a result, the coinsurance rate--the percentage of added expenses that the patient, rather than the insurance plan must pay--decreases from about 86% at an income of $3000 to about 55% at income above $50,000.

In the IRS plan the net effect of these deductible and coinsurance provisions is to provide greater tax savings and protection against

medical expenses to high income taxpayers. I estimate that in 1970 the average tax savings of taxpayers with incomes less than $5000 was about $35, while taxpayers with incomes above $50,000 enjoyed an average savings of at least $175.

It is natural to ask how the medical deduction would fit into a full-scale program of national health insurance. One possibility would be to change the structure of the present IRS plan from a tax *deduction* to a tax *credit*. Under a tax credit provision, the taxpayer would be permitted to subtract a specified fraction of his medical expenses from the amount of tax he would otherwise be required to pay, instead of deducting those expenses from his income, as is currently done. Such a modification would direct substantially more tax expenditures to lower income taxpayers. A somewhat different approach would both institute a tax credit and raise the 3% of income limit to perhaps 15% of income. This modification would convert the IRS plan into a form of catastrophic insurance coverage. In any year benefits would be paid to only the small proportion of taxpayers who incur large medical bills. By paying tax refunds in the few cases in which the tax credit would exceed the tax owed, such a plan could provide complete protection against financial disaster.

## Conclusions

Federal tax policy toward personal health care has encouraged voluntary purchase of health insurance and has provided tax assistance for medical expenses. Today the tax expenditures for these purposes represent a significant proportion of the public sector budget for health care.

In the debate over the establishment of a comprehensive program of national health insurance, the provisions for financing have emerged as a key obstacle blocking agreement on new legislation, because the choice of a financing mechanism will determine how the costs of a new program will be shared. Different combinations of premiums, payroll and income taxes, and out-of-pocket payments allow a program to be designed to achieve nearly any distribution of costs, ranging from a plan that has approximately equal costs and benefits at every level of income to a program that creates a substantial degree of income redistribution. By defining the cost implications of specific proposals and by suggesting alternative means by which they could be funded, economic analysis can contribute to the public discussion of this major national issue.