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Public Finance Principles and National Health Care Reform

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Public finance principles lie at the heart of effective national health care reform. In most discussions, however, they are treated as a minor consideration, worthy of attention only in rare circumstances when they become bothersome. These comments identify four principles of public finance that are salient in raising revenue and spending it for health care. Readers are encouraged to provide others.

Principle 1: Charge For a Service Where Its Cost is Created

Since the cost to insure an individual does not depend on where that individual is employed, costs are created by the individual's existence, not the locale of employment. Hence, different employers should not be charged different amounts for the insurance of the same worker. Indeed, since whether a given individual is employed does not (much) affect the cost of that individual's insurance, employer-based charges for insurance should be recognized as a fiscal and political convenience, at best.

It is true that under the Clinton health care plan's employer-based premiums, a worker's benefits will not vary by workplace. However, firms that differ in size and average wage will pay dramatically different premiums for the same individual at the same wage, as argued in the papers by Pauly and Aaron. The immediate implication is that an arbitrarily imposed insurance cost, rather than simply the productivity of the worker, will determine who is hired at which

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firm. A more subtle implication is that firms will split, combine, and contract services to optimize their mix of personnel to reduce insurance costs.

Principle 2: Distinguish Rents, Resources, and Transfers

Resources do not flow smoothly into and out of the health care sector. For example, personnel require extensive training, and many health care facilities are specialized and exceedingly expensive capital assets. If health care reform cuts back expenditures, many resources will be idle or will be shifted to less remunerative activities. Though we may curtail substantial quasi-rents—that is, specific factors will be paid noticeably less—those actual resources are not readily freed up for alternative uses.[1] The marginal cost of many health services, the appropriate guideline for efficiency, may be well below both average cost and price, where price is the likely lodestar for policy-makers.

The presence of massive rents also suggests wariness about rent-seeking. A hospital whose wing is about to be closed or a specialist who may be cut out of coverage will try hard to secure favorable consideration from a health alliance or with those providing organizations who have contracted with the alliance. Competition, perhaps by having more than one alliance in an area, may be the best way to defuse wasteful rent-seeking.

Aaron's paper alerts us to another form of transfer that will arise with health care reform. Various industries will save or lose substantial amounts from the move to community rating. His rough estimates suggest that such a move will cause changes of roughly $1,000 per full-time employee. These transfers are substantial. They will tend to handicap start-up firms, which tend to employ younger workers; allow established industries to escape the escalating cost of their aging workforces; and subsidize less healthful occupations. Each of these will bring an accompanying political fallout.

Principle 3: Know What Different Services Cost, and Pay Accordingly

Long division is usually the most important tool of policy analysis, for it yields information on unit costs. With health care, matters are more difficult, since resource utilization varies dramatically among individuals. This suggests that providers should be reimbursed on the basis of their patients' attributes; for example, scaling payments to the age and identifiable health characteristics of their patients. Otherwise providers would seek a more profitable mix of insureds—that is, they would cream skim.

[1]Similarly, offloading expenditures from the government budget—say, by requiring that employers or individuals pay the cost—does not offload them from society. Proper accounting for a health plan looks at real resource use, including possible deadweight costs for financing.

Aaron challenges the idea of experience rating, and finds that it is vastly overrated by economists. His focus is on charging individuals on the basis of their behaviors, or firms on the basis of their employee mix. I suspect he would (and should) prefer experience-rating *providers*—that is, finding how much they spend to serve various classes of patients, and redirecting customers and paying premiums on that basis.

Moreover, although efficiency rating certainly causes some problems, it is worth noting that community rating is also an arbitrary practice with haphazard equity implications. For example, who pays for the excess health care expense of the waiting-for-Medicare contingent of Sun City or the problem-ridden residents of the South Bronx? The purchase of insurance on a local geographic basis may be convenient, but that doesn't make the result fair. Moreover, it is hardly necessary that payments be averaged and uniform throughout a territory. Even with the warnings about experience rating in mind, payment groups should probably take other factors into account, and apply to a larger area than the logical geography for a health alliance.

Principle 4: Balance Distributional and Efficiency Concerns

Policy deliberations tend to look at the progressivity of charges and benefits in each area, such as health or education, rather than exploring how appropriate overall progressivity can be achieved at the lowest efficiency cost. The Clinton health care plan is unfortunate in this respect. It relies on employment-related payments, which are assuredly regressive, and then seeks to adjust matters toward "equity" with complex schedules and subsidies.

The problems of insecure insurance and uninsured citizens, which along with rising and excess costs have been principal spurs to health care reform, can only be addressed with new moneys. (Even if health care reform saves money, it will still require additional funds, since the savers—be they individuals, families, or businesses—will keep their gains.) Consider an alternative crisis: say, dramatically increased military costs due to chaos in the Commonwealth of Independent States. If society needs an incremental $100 billion to address a crisis, there is little economic reason that the source of financing should depend on the area of the crisis.

Applying Public Finance Principles: An Alternate Vision of Health Reform

Let us apply these four principles to the Clinton plan's potential effects on employment and labor force participation.[2] For example, with insurance costs

[2]In his contribution, Cutler identifies some main changes as job gains for welfare recipients, losses for present workers, and induced retirements.

tied to employment, first-time insurers will incur significant new costs; newly-insured workers, particularly those paid near the minimum wage, will be much less competitive. Taking direct inspiration from Rube Goldberg, the Clinton plan attends to these concerns through complicated subsidies and caps, relating to both the average wage and size of a firm. The principal goal appears to be to reduce costs of employment for small firms and low-income workers.

One might justify the small firm subsidies as a response to a powerful political bloc, and the subsidies to low-income workers on the grounds that they have had a tough time in the 1980s, as their productivity relative to the mainstream declined. But whatever the justification, economics abhors such complex systems of charges; they usually produce glaring discontinuities, inequities, and bizarre incentives of their own, as Pauly and Aaron demonstrate in the case of the Clinton plan.

The above principles of public finance—1 and 4 in particular—suggest a more radical financing system, which would generate less distorted outcomes in labor markets. Once we recognize that employment does not affect health care costs, we gain at least intellectual freedom from the need to finance health care in the workplace.

If the government chooses universal basic health insurance coverage, by logic this coverage should become an obligation of government, which it can finance through mandates on individuals or employers, or by any other form of tax, such as a consumption tax. I suspect the Clinton administration arrived at employment-based payments without probing the concept at a fundamental level. It may not have considered, for example, the possibility of financing incremental insurance—say for low-income, unemployed, or marginally-employed workers—outside the mainstream employer-based system. The reasoning might have been: "That is what we have now, the government is carrying a deficit, taxes are politically difficult, and we can hit employers for the money."

I can think of two principal arguments for employment-related payments. First, it may be that the tremendous ability of potential losers to resist change requires that we build on the present employer-payment system. If this is true, then discussion is ended. Second, it may also be that given the overall mix of taxes in effect, it is desirable to shift taxes toward payroll or head taxes, or conceivably the melange of the Clinton plan. This question, at least, is open for discussion.

Begin by considering the general question of how health costs should be financed. Economics argues that individuals and firms should pay health care costs at the margin to the extent they can control them. Thus, they should be charged 100 percent at the margin if they select health plans within which they will cost more.[3] Ideally, society would charge individuals the net costs of health-impairing behaviors, and reduce firms' costs for installing

[3]Even if we wished all ages to pay the same base premium, there is no reason why 60-year-olds could not be charged more than 30-year-olds for picking enhanced plan B over base plan A.

health-promoting efforts in the workplace. But for the most part, little monitorable behavior by the individual or the firm has much effect on health costs (as Aaron points out).

Given that the United States will retain progressivity in its tax system, it makes little economic sense to impose a head tax or capped payroll tax as an incremental measure. The taxes at the bottom of the system, where one might receive a covered but low-paying job, are particularly severe. Moreover, constraints related to minimum wages come into play. Even with its mishmash of subsidies, the proposed system's highest implicit tax rates will be paid by those at the bottom of the employment spectrum.[4] In short, since employer-paid health care costs are overwhelmingly paid by workers, the Clinton plan relies on a regressive financing system. Though where you work does not significantly affect your health costs, at least low-income workers are likely to pay different health insurance premiums depending on their employer. We thus reap the worst of both worlds: a regressive financing mechanism with market-distorting incentives.

By contrast, the optimal tax literature supports the possibility of having the government fund or partially fund a universal coverage system, raising revenue wherever it can most efficiently. Surely a broad-based value-added tax, at least to cover the costs of many presently uninsured such as unemployeds and low-income workers, would merit serious consideration.[5] For higher income workers a mandate on individuals or employers may be preferable to tax-based financing, since the latter incurs deadweight loss. The government could either pay health providers directly, fulfilling the dreams of many liberal opponents of the Clinton plan, or it could funnel the moneys through insurance companies, health maintenance organizations, and other intermediaries.

Should the choice of financing system vary according to one's political values? The Iron Law of Redistribution suggests not. It states: The overall degree of progressivity of government programs at any time is fixed, reflecting the preferences of the non-poor majority operating through the political system. Thus, what lower-income citizens secure in one area, they will give up in another.

The Iron Law is overstated, but tin, a more flexible metal, provides an apt metaphor. The Tin Law observes: Additional redistribution in one area will be substantially offset over time by lost redistribution in other areas. Conservatives who accept the descriptive validity of the Tin Law should recognize that a head tax for health care is not what they want—since it will lead to greater progressivity in some other area of the tax code. Liberals who accept the Tin Law

[4]Society has nonaltruistic concerns with the employment of such individuals. Employment will reduce social welfare payments, thereby providing a fiscal externality. A real externality will flow if, as is frequently alleged, employment diminishes social problems.

[5]The optimal income tax literature, with its concern for having high-income individuals earn a great deal, usually prescribes decreasing marginal tax rates. That literature would propose far lower marginal tax rates at the bottom if it took account of the positive externalities for society associated with employment of low-income individuals.

should shun a contorted premium structure that sacrifices too much efficiency for too little redistribution.

Conclusion

Chess wizards, it is said, can readily memorize a dozen boards from experts' games, but have difficulty remembering a single board with pieces randomly arrayed; underlying principles make the layout of the experts' games comprehensible. In his opening sentence, Aaron remarks on the complexity and intricacy of the Clinton plan. Pauly, in concluding, notes that its financing seems chosen to make it difficult for voters to judge what they will be paying and getting.

The problem, I suspect, is not one of purposeful obfuscation, but rather a system that was patched together to address various political demands and policy concerns. Instead, meaningful national health care reform should follow public finance principles. Any plan that does so would offer the secondary benefit of being readily understood, at least by economists.

The authors in this symposium practice what I preach. They use economic reasoning to gain insights into how national health care reform should be designed and instituted.[6] The labor market effects of financing merit particular attention, because employment status has little effect on health costs. More generally, we should think of the financing of health care as part of the broader question of how to pay for all government and government-imposed expenditures. Given justifiable concerns about the deficit, there is a danger that government will impose woefully inefficient expenditures on other parties rather than pay itself.

Public finance principles, lodged at the heart of health care reform, are sending out some worrisome messages. Just as citizens should not ignore chest pains, our government leaders should pay heed to these warnings.

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[6] Politics is eschewed in these essays, but I suspect politics strongly influenced the topics chosen.

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1. George Karatzas. 2000. On the determination of the US aggregate health care expenditure. *Applied Economics* **32**:9, 1085-1099. [Crossref]