

Would employment-based health savings accounts help Medicare?

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This paper was stimulated by the Editorial of Dr Vince FitzGerald in the last issue of AHR on health aspects of a comprehensive retirement policy (FitzGerald 2000). His main arguments were that increased retirement savings are desirable, that there should be savings specifically for health care, and that the health savings should be a mix of pooled and individual savings. He justified savings mainly on the grounds of economic prudence and equity for our children.

He discussed a variety of arrangements whereby the savings could be accumulated, including linked and separate income and health savings accounts; optional ways of using health care savings such as for any care or for care only after retirement, and for self-pay or the purchase of private health insurance (PHI); and optional premium contribution and copayment models. In short, he covers most of the kinds of arrangements that are in place in countries like Singapore, Chile, and China.

The arguments are clearly articulated and carefully analysed, especially in his more detailed paper on which the Editorial is based. Our concern is not with the basic ideas, but with the risk that some may be misconstrued and carelessly applied by others.

The case for increased savings is well presented, as are his ideas about the formulation of a policy that links health care with other features of retirement. However, the next level of design presents a more complicated set of questions of which we will mention four: should savings be health-specific or general, should savings be pooled or individual, should the funds thus accrued be used as contributions to public or private health insurance, and should there be separate savings arrangements for employed and not-employed segments of society?

The arguments for health-specific savings are similar to those for health-specific taxes, and are not entirely convincing. It is often claimed that specificity ensures adequate resources will be available, but this is unlikely to be the case: specificity may guarantee that the level is known but not that the level is appropriate. It is also regularly suggested that specificity ensures the community knows the high cost of health care, but there are other ways of stressing the obvious. Perhaps the main argument against health-specific taxes or savings is that it "... limits governments' ability to change priorities when social and economic changes occur" (Podger 1986).

The choice between pooled and individual savings is much more complicated, because it depends on one's views about individual and collective responsibility. For example, the Chinese government has rejected the high level of social pooling typified by countries like Canada and Sweden on the grounds that Chinese cultures lean towards greater levels of family and personal responsibility. There is also a pragmatic reason for China taking this path. Like other former centrally planned economies, it has a poorly developed taxation system. The evidence suggests that views of the community in Australia are closer to (say) Canada than China, but some people argue that the situation has been changing over the last decade or so.

Dr FitzGerald notes that the savings for health care could be used as contributions to public or private health insurance but he expresses no preference. The current government clearly prefers a move towards the latter, and one might reasonably argue that all Australian governments have shown this tendency since Senator Richardson was Health Minister in 1995. The most obvious benefit for governments is that they can reduce taxation levels. However, Naomi Caiden (1988) argues this means no more than replacing government with "privatised" taxes which are generally more expensive to collect and more regressive. Governments might also believe that they

can shift some of the blame for inadequate services onto non-government agencies (and onto the private health insurers in particular).

We have a strong view on this matter: public insurance is to be preferred. PHI does nothing that the tax system doesn't do better. For every dollar that passes through the tax and Medicare system, only four cents goes on administration; for PHI the administrative overhead is twelve cents. The Tax Office does not have to offer gym shoes or overseas travel as enticements to pay tax. Nor does it have to rely on clumsy and inequitable schemes like lifetime community rating to achieve a fair distribution of the burden of financing health care.

A single national insurer like Medicare can also keep control on service providers' charges. That is well researched: countries that have strong national insurers also have low cost health care systems. PHI, by contrast, does not have the power to control high charges by service providers and to keep over-servicing in check. Like public insurance, PHI suffers from moral hazard - that is, the absence of any price signals at the time a service is provided. There is no difference between the attitude "Medicare will pay" and the attitude "HCF will pay". However, private health insurers are less able than a single national insurer to confront the concentrated power of medical service providers. A good example is the sensible idea of competitive contracting of hospitals, recently introduced in a restricted way by several Australian insurers including National Mutual and MBF. Whereas the State and Territory health authorities have been successfully applying competitive contracting for many years where it is helpful, the private insurers have been facing fierce opposition from many private hospitals and medical specialists.

The Singapore system, which Dr FitzGerald succinctly describes, is protected against the disadvantages of PHI as it operates in most countries, including Australia. In discouraging additional insurance there is some protection against moral hazard. Although it is non-government, it does not have the problems of cost control faced by fragmented PHI in other countries. In that regard, it is a model of just what most health economists advocate - a single national insurer.

Dr FitzGerald proposes that savings be accrued by mandatory contributions at the place of employment, in much the same way as superannuation. This makes sense in terms of national savings, but it presents some dangers of further separating the employed and not-employed segments of society. His proposals are largely neutral with respect to employment- rather than tax-based insurance, on the reasonable grounds that we have to build on what appears to be unchangeable at present. Our concern is that others may interpret his proposals as a vote in principle for this approach, and we therefore believe it is important to point out where the wrong road could take us with respect to linking health insurance to employment.

The USA went down that path in the post-war years, as an alternative to the national health schemes that were being adopted in Europe. At least Australians who take out private insurance on their own account have some notion of what it costs. In the USA, where employers make the contributions, there is no such awareness; the only vestige of a price signal is suppressed.

Americans pay dearly for employer-funded health insurance. It is paid in a combination of wages being lower than they would otherwise be, and in higher business costs, to the detriment of international competitiveness. Without such contributions, taxes would have to be higher, but Americans with a national health insurance scheme would be paying only around 8 per cent of GDP for health care, rather than 14 percent, which is the cost of leaving health care funding to a fragmented private system. Even at that high price, 40 million Americans are left uninsured.

Australia has an annoying habit of picking up those health policy ideas from the United States that the Americans are most eager to try to put behind them. As Gabel (1999) puts it, job-based health insurance is 'the accidental system' that never worked well and is becoming progressively less satisfactory. One problem is that its coverage continues to decline. People most likely to miss out are those working for small companies that cannot afford the administrative burden of managing a scheme (Hing and Jensen 1999), non-college-educated Americans (Gabel 1999), children (Frenkel 1998), women (Short 1998), and part-time employees (Thorpe and Florence 1999). In short, job-based insurance favours the privileged and powerful and further disadvantages the disadvantaged.

The plight of children in the USA is worthy of special mention. Yudkowsky & Tang (1997) point out that one of the consequences of increased cost of cover is that large numbers of employers are eliminating or reducing

insurance benefits for dependants. Most States, through their Medicaid programs, are trying hard to stem the tide of uninsured children. In other words, the market's deficiencies are having to be alleviated through government financing from general taxation. It is surely about time to ask whether, rather than doing it right as a safety net, the job should be done right from the beginning. The argument in the USA (and in Australia of late) has always been that everyone should have the freedom to make his or her own choices about health insurance. The imprudent who choose not to take up private insurance deserve what they get. We find this argument unpleasant when it comes to children whose freedom of choice is limited at best.

The US experience of employment-based health insurance is neatly summarised by Bodenheimer and Sullivan (1997). They note that it is facing increasingly serious problems, partly because of the decline in coverage and increasing inequities of coverage. The proposed 'employer mandate' legislation that would require all employers to offer schemes is unlikely ever to pass, but it would be a Band-Aid solution at best. They conclude that employment-based financing "... is regressive and complex" and an alternative solution is required. The right answer is progressive income taxation on the grounds of greater equity and reduced administrative cost. They observe in passing that "... the political feasibility of such a tax is greater than that of employer mandate legislation."

Similar arguments are presented by Light (1999). He argues that improvements in the cost-effectiveness of the US health care system "... depend on stable (insurance and health care) contracts and universal coverage." However, current arrangements mean that employers have incentives to try to avoid covering their employees. Worse still, they are encouraged to participate in "... a market of lemons" whereby cheap health insurance plans are bought and sold in order to deal with perceptions about employment benefits rather than to ensure there is access to cost-effective health care. There is a conflict between adequate health insurance benefits and the cost of cover: if costs increase in order to improve quality, there will be a further increase in the number of uninsured persons. Light argues that "... this tragic choice, which no other industrialised nation has permitted, will not be resolved until some form of universal health insurance is implemented."

The idea of employment-based insurance is not new to Australia. Throughout the 1920s and 1930s, Australia engaged in a serious debate over the advisability of creating a National Insurance Scheme (NHI). Its main features were simple: employers and employees would be required to establish and make contributions to health insurance funds. The origins of the NHI were in a confused set of ideas about health, including the need to have an efficient industrial and commercial workforce, and the importance of providing another source of financing of private medical care. However, it was more than anything a fiscal policy: the employed have money, and the state should seize some that money before it was at risk of being spent in other ways.

Federal leader of the ALP, John Curtin, put it neatly when he participated in the final defeat of NHI (Curtin 1938). He pointed out that it was essentially regressive. "While purporting to deal with a national problem, the bill contemplates an anomalous system of class taxation. Its benefits are not equally shared, and its burdens are not equally distributed." It was not possible to deal with the social obligations of caring for the aged, disabled, and sick by taxing only the employers and the employed. He was angry about the notion that, if you were in the workforce for a long time, then you deserve more benefits than those outside the wage economy. He was vehement in his attack on the gender bias: given that women had lower participation rates and lower wages, their benefits would be smaller or non-existent.

Employer-funded health insurance makes even less sense now than it did in the middle of the last century, when lifetime employment with one firm was a distinct possibility. Employment is likely to be episodic for most people, with periods of full-time employment, part-time employment, self-employment, unemployment, casual employment, housekeeping, parenting and study. Those who suffer chronic illness, who are most likely to be able to benefit from private insurance, are least likely to find themselves in a job with significant employer contributions to health cover, or indeed in any job at all.

A related concern is the recent interest among some trade unions in making PHI a component of enterprise bargaining agreements. For a union official, trying to win benefits for members, employer-funded health insurance has an immediate attraction. It would, however, be at the cost of the more enduring benefit of Medicare. What looks attractive for a workforce in an individual workplace looks far less attractive when considered in a wider context. One enterprise bargaining agreement incorporating private health insurance

may look very appealing. If every enterprise agreement incorporated private health insurance, however, it would be disastrous for the entire community; premiums would rise steeply (at the expense of wages or corporate profits), and those temporarily or permanently out of work would be left with an impoverished Medicare, which would have to pay prices set in an unbalanced market with powerful service providers and weak insurers. That is essentially what has happened in the USA, where the two limited government insurance schemes, Medicare and Medicaid, account for about the same proportion of GDP (6.5 percent) as comprehensive schemes in many other countries (OECD 1999).

Unions would do better to bargain for higher pay rather than health cover - leaving the decision on whether or not to take private insurance to the individual. Moreover, health cover at the expense of superannuation would be at the expense of savings and retirement benefits because PHI, being a pay-as-you go scheme, does not contribute to saving.

The Coalition government has said little about the ideas raised by Dr FitzGerald, but the Shadow Minister for Employment, Simon Crean has indicated an interest in some of the elements. It appears that the ALP's health specialists (from the Shadow Minister Jenny Macklin to the many other clever and knowledgeable people like Chris Evans, Carmen Lawrence, and Mark Latham) are more cautious.

One would hope so. It is usually sensible to establish stronger links between health and other policy areas, but there are always risks. A recent example was the 30% PHI rebate: the Federal Minister for Health, Dr Wooldridge, is as aware as anyone that the 30% rebate was a Cabinet taxation and election policy rather than a sensible idea about health care. Whether it was a sensible taxation policy is debatable, but there can hardly be any doubt that it has damaged the health care system.

The Australian Labor Party (ALP) has long understood the risks associated with PHI, but it seems to have become increasingly more prone to ignoring them since Senator Richardson's brief stint as Health Minister in the early 1990s. This is well illustrated by the recent statement by the Opposition Leader that he will not abolish the 30% rebate in spite of concern by many health-wise ALP members over its inefficiency and its contribution to social inequity. His argument seems to be that, since adding the rebate did little to increase PHI membership, then taking it away would lead to a large and sudden decline in membership - and this would be disastrous. This logic is certainly half-sound: removing the rebate (and therefore adding 30% to the cost of premiums overnight) would result in a large drop in membership. However, the assumption that this would be bad is debatable. All that would be lost is a financial intermediary which adds a \$560 million annual overhead cost on to health care. The money thus saved by the government could buy far more cost-effective care under public insurance.

Medicare was introduced as part of the social wage. Health cover was not to be left to the discretion of employers, or funded by a clumsy system of subsidised private insurance. Rather, it was to be funded as a community-wide responsibility. Those who designed Medicare knew the problems of private insurance and employer funded schemes; they had a generation of US experience to draw upon which confirmed the foresight of John Curtin. It seems strange that the ALP, having developed a low-cost universal system, well accepted by the community, has promised to continue the subsidy and may be considering high-cost corporate-based welfare, both of which would undermine the very system it introduced.

In summary, there are many ways of ensuring there are increased savings - and therefore that it will be easier for Australians to obtain satisfactory health care in 30 years' time. Dr FitzGerald's ideas are sensible, and are consistent with the general strategies of Australian governments over the last decade or so.

There is, however, a quite different approach that needs to be considered: that of encouraging pooled savings for all uses and leaving the health sector to build on Medicare. This would not present the same accidental risks to health care, or provide as many opportunities for Medicare's opponents to damage it by stealth.

The issues and options are complicated, but one aspect is easy to see: a single funding source will always outperform multiple sources. The main worry is that, whenever there are other buckets labelled 'Not Medicare' there will be temptations to transfer to them the funds that would have been better spent through Medicare. This was well illustrated by the 30% PHI rebate. The proponents claimed it was new money, but this is not supported by the evidence: health spending as a proportion of GDP has not changed since the rebate was introduced. If you want further confirmation, talk to some of the pensioners who lost their Medicare

entitlements to dental care in 1997 how they feel about the subsidies for dental care now being provided to people with private health insurance. Many of them might well see health care financing as a zero-sum rather than the win-win game promised by the Coalition.

One interesting aspect of the fight over Medicare is that opponents claim the need to establish and strengthen other sources of funding in order to protect it. The 30% rebate was a way to 'take pressure off the public hospitals'. It is true that some patients have been moved away from their dependence on money in the Medicare bucket, but the bucket shrank by \$2.2 billion a year as a consequence.

Dr FitzGerald's has done us a good service in raising the issues of national saving; with declining household saving the issue is even more pressing now than it was in 1993 when he produced his National Saving Report. On health care he raises a number of important issues; we do have to consider how to fund health care for an ageing population, and to consider the role of individual as against pooled funding. On the former we are fortunate in that we can look to see how other countries, such as the much older northern European democracies are coping. On the latter we do need more debate - our present approach comprises a complex and incoherent mixture of "free" services and others with substantial, sometimes open-ended out-of-pocket costs.

We would urge caution, however, in linking health care funding to employment. There are too many risks to equity compared with spreading funding through taxation. If all or part of our health care funding is to be pooled, we see virtue in doing that pooling through a single national insurer, rather than through a fragmented PHI system. If, like the USA, we rely on PHI for that pooling, we would probably develop a system which is not only inequitable, but which is also extremely expensive.

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