

Impacts on Households

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INTRODUCTION

In the debate over health care reform, there is much discussion about the distribution of the burden of financing among various payers, that is, among government, business, and individuals. If, however, “ultimately. . . the individual bears the primary responsibility of paying for health care through health insurance premiums, out-of-pocket costs, philanthropic contributions to health organizations, income taxes, earnings reduced by increases in employers’ health insurance costs, and higher cost of products’ (33), as well as for the tax subsidy for employment-based health insurance premiums, then a key area of scrutiny is the impact of reform approaches on household¹ income. Furthermore, the impact on households by income level and type of household (i.e., the so-called distributional effects among households at different income levels, different family compositions, and different health status) should be examined for any differential impacts ensuing from the various reform approaches.

¹ Analysts reporting their estimates of the impact of health care reform on households tend to use the words “household” and “family” interchangeably and OTA did not attempt to redo analyses based on any standard **definition** such as that devised by the U.S. Department of Commerce, Economics and Statistics **Administration**, Bureau of the Census; that is: “[h]ouseholds consist of all persons who occupy a housing **unit**. . . A household includes the related family members and all the unrelated persons, if any, such as lodgers, foster **children**, wards, or employees who share the housing unit’ whereas *families*, which are a subset of households, “are groups of two persons or more (one of whom is the householder) related by **birth**, marriage, or adoption and residing **together**, all such persons . . . are **considered** as members of one family” (emphasis added) (91). In 1991, there were 95,669,000 households but 67,173,000 *families* in the United States (91). Thus, quantitative estimates of the impacts of health care reform on ‘households’ and ‘families’ are not comparable. And when the same analysis uses both terms without **defining** either one, the basis for any estimates is all the more unclear.



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In evaluating and comparing analyses of the impact of health care reform on households, it is important for policymakers to keep in mind the scope and types of **effects that the analysts** considered. As suggested **above, these consequences** can be limited to the so-called *direct effects of households' share of national health expenditures*, as calculated by the United States Department of Health and Human Services, Health Care Financing Administration, Office of National Statistics (33); this is the method used by the Congressional Budget Office in its analyses.² More narrowly, analysts may restrict their estimates to impacts on households' *private health insurance costs* only (40). Less frequently, **analysts may discuss the indirect costs of the tax burden** on families to support the Federal Government's open-ended tax subsidy of employment-based health insurance premiums (72). Even more rarely, analysts may include potential gains in compensation (e.g., wages to working members of households) that may result from employers' reduced liability for employees' health insurance premiums (67). As noted throughout this report, all of these impacts may potentially **offset each other**, either partially or fully, at least for some people (e.g., gains in wages may be offset by increased taxes under a Single Payer or other plan; gains in wages maybe offset by additional out-of-pocket costs if a plan incorporates high patient cost-sharing), and analyses may not identify and discuss the implications of such potential offsets. As in other comparisons in this report, this chapter presents the quantitative results of analyses, providing explanations in the text, the tables, and in appendix B. The primary message for policymakers is the need to exercise caution when comparing numbers.

Direct and Indirect Spending in NHE Terms

While direct spending on health remained fairly stable from 1984 through 1991 as a percentage of nonaged household income (22), combined direct and indirect spending on health care in national health expenditures terms represent an increasing portion of the family budget (19). According to an analysis by Lewin-VHI conducted for Families USA, families' average annual health payments,³ as a percentage of average family income, increased from 9 percent in 1980 to 11.7 percent in 1991 for an average of \$4,296 in 1991. Moreover, Families USA projects an **increase in** average health payments by families to \$9,397 in 2000, representing an increase of 439 percent since 1980 (19). The report stated that, "[t]hese **estimates** understate the burden of health care costs on families since there is no attempt to determine how much of business health expenditures are simply passed back to individuals through lower wages, higher prices or reduced payments to shareholders" (19).

According to the CBO, medical care cost increases have widened the distance between the growth in wages received by workers and **that of** total employee compensation paid by employers (54). CBO found that in almost every year in the 1980s, total fringe benefit costs, of which rising health insurance costs were a "major factor," rose faster than wages and salaries (54). To the extent that this disparity decreases the real cash wages of employees, households may be adversely affected by increasing health care costs that consume income that they could put to other uses.

Indirect Spending Through Federal Taxes

In his examination of tax policy related to health care reform, Steuerle proposed that the

² "Direct spending on health" as defined by the Congressional Budget Office, "includes the amount directly paid for health insurance premiums by a household, as well as other out-of-pocket expenses for health services" (22).

³ Health payments were defined by Families USA as "the delivery of **all health services** and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public **programs**, and the net cost of private insurance." It excludes non-patient revenue, research and construction (19).

current tax subsidy for employment-based health insurance benefits essentially constitutes an open-ended health program provided by government (72). Because this open-ended subsidy results in a tax impact on households, Steuerle maintained that individuals are ignorant of both the cost of the health care they receive and are deterred from knowing the cost of the health insurance that they purchase through their employer. He estimated that the average health care *expenditure* (which includes the value of the tax subsidy provided by government) per household in 1992 was \$8,000, of which only about one-third was paid *directly* by individuals and of which a large portion was hidden (72).

Hence, the various reform approaches, to the extent that their design redistributes the financing burden placed on families (e.g., through mandating the purchase of insurance, eliminating or limiting the tax exclusion for employment-based health benefits, or mandating employer contributions to employee health benefits where they were not provided previously) will have an impact, be it obvious or hidden, favorable or adverse, on household income.

IMPACTS OF SINGLE PAYER APPROACHES

The economic impact on households of approaches in which the government is the sole purchaser of services will turn most on the financing mechanism adopted (e.g., general tax revenues, payroll tax, value added tax [VAT]⁴).

Also significant will be the extent to which the system eliminates or limits cost-sharing at the point-of-service by individuals (82). Under a tax-financed universal coverage plan, employees (and thus, households) as a group may benefit to the extent that employers are left with additional funds after taxes which may be distributed, at least in part, to them. To a lesser extent, households may experience some gain due to reduced time expended handling health care administrative tasks (e.g., claims forms) (83).

Silow-Carroll's analysis of a Canadian-style system projected initial impacts on consumers (in the year 1994) ranging from net *savings* to consumers of \$10.0 billion to a net loss of almost \$20.0 billion (67). Cumulative estimates from 1994 through 2003 ranged, in current dollars, from *savings* of \$3.0 to \$4.4 trillion (67) (table 4 in chapter 1; also see appendix B). These estimates took into account changes in both consumers' direct spending and in their tax liability. The estimated impact on consumers depended primarily upon the degree to which the system gained control of the rate of health care cost growth. Also important was the extent to which employer gains, due to the elimination of their health insurance costs, were distributed to labor. Thus, under the study's "Pessimistic Scenario,"⁶ an initial loss and lower cumulative savings were estimated whereas under the study's "Optimistic Scenario," some initial savings and greater cumulative savings were projected (67).

⁴ "Value-added tax" or VAT is defined as "[a] tax which accumulates on goods as they move from raw materials through the production process. Each processor pays a tax according to the amount by which he has increased the value of items that were raw materials to him" (44).

⁵ With respect to the cumulative estimates, the study assumed that, after taxes, 50 and 80 percent, respectively, of employer gains were distributed to labor (67).

⁶ Silow-Carroll's "Pessimistic Scenario" assumed that "after expanding coverage to the uninsured, we achieve only a 2 percent reduction in spending compared with business as usual in year one. Further reductions are experienced in the second and third years, and the future health care spending growth rate is slightly faster than the rate of growth in GDP (67).

⁷ Silow-Carroll's "Optimistic Scenario" assumed "an immediate 10 percent reduction in spending, offset in part by an expansion in coverage, netting an 8 percent decline in total spending for 1994. The following two years would experience additional reductions of 5 percent each, representing a phasing-in of savings from conversion to a single-payer system, consolidation of duplicated services. . . . and other efficiencies. This scenario also assumes that after the first three years, the growth in health care spending would be reduced . . . to the same rate as the economy, or about 7 percent per year" (67).

IMPACTS OF PLAY-OR-PAY APPROACHES

In general, critics of the Play-or-Pay approach claim that the required employer contribution is essentially a tax levied on those least able to afford it (i.e., low-income workers and their families) (5). They further maintain that it results in negative redistribution effects, posing a significant financial burden for working-poor and near-poor people who do not now have employer-sponsored health insurance and who “most economists” believe “would effectively pay the full cost of their health insurance under ‘play-or-pay’ “ unless employers absorb these increased costs (48).⁸

Some analyses of Play-or-Pay approaches to health care reform have increased premium cost-sharing for employees and/or their dependents, which would increase households’ health insurance costs even if total health care costs are held constant (100). This raises the question of the ability of low-income families to afford their requisite premium share. Safeguards such as requiring all working adults to be insured through their own employers (thereby limiting the number of employees with adult dependents for whom, presumably, the sponsoring employer would pay a smaller share than would an individual’s own employer), and government subsidies for low-income families, may help alleviate some of the increased burden on low-income households resulting from employer mandates to sponsor coverage (98).

Estimates of the impact of an employment-based approach on households range from *savings* of \$19.3 billion in 1990 (75) to *increased spending in 1993* of \$2.3 billion (37) (table 4 in chapter 1).

While not dispositive of the difference between these estimates, factors such as assumed increased taxes in one estimate (increased spending of \$2.3 billion) versus no revenue-raising assumptions in the other (savings of \$19.3 billion),

differences in the assumed baseline year and health care costs of employers, and the payroll tax rate—7 percent where savings are estimated (75) and 10 percent where increased spending is estimated (37)—appear to contribute significantly to the difference in estimates.

To the extent available, detailed discussion of the impact of an employment-based approach on households, by income level, appears in appendix B.

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

If Individual Vouchers or Tax Credits approaches to reform function as intended, insurance coverage should be more available and affordable, thereby decreasing the cost of health care to households in the aggregate and increasing many households’ funds available for other purposes. If, however, the resulting tax credit, deduction or voucher is insufficient to purchase adequate coverage, households will be no better off and some may be worse off than under the current system (65).

Lewin-VHI’s analysis of the Heritage Foundation plan on behalf of the Foundation estimated that households would save \$18.8 billion in 1991 (35). Silow-Carroll’s analysis of the Bush Administration proposal estimated savings in 1994 of \$7 billion (65). Silow-Carroll also estimated cumulative net *savings* for the Bush plan, in current dollars, of \$400.0 to \$700.0 billion from 1994 through the year 2003 (65) (table 4 in chapter 1).

The Lewin-VHI analysis of the Heritage plan assumed that increased household health care spending (limited to households’ direct spending for health insurance) would be offset by increased wages (given the proposal’s provision that employers that discontinue coverage must convert the value their contribution to such coverage to employee income during the first year, and assuming that all employers discontinue cover-

⁸See also chapter 5 and appendix B regarding the potential employment effects of mandatory employment-based insurance.

age). Silow-Carroll's analysis of the Bush plan focused on the net impact of the proposal on consumers' from the tax credits or deductions, and changes in "after-tax wages, out-of-pocket spending for health care, prices of goods and services, and dividends and stock values" (65). It assumed varying degrees of success with respect to the proposal's ability to achieve ongoing reductions in the rate of health care spending given its voluntary, incentive-based approach.

IMPACTS OF MANAGED COMPETITION APPROACHES

As with Individual Vouchers or Tax Credits approaches, if Managed Competition approaches to health care reform function as intended (that is, improve access to and the affordability of health insurance) households' average health care costs should decrease. In some Managed Competition proposals, specific cost-containment mechanisms appear to heighten the potential for decreased national health care expenditures in the aggregate and, thus, for decreased households' health care costs. There are few analyses to date, however, of the specific impacts of Managed Competition approaches on households' health care costs. One recent analysis of a Managed Competition proposal by Long and Rodgers focused on its impact on households' private health insurance costs (as opposed to total household health care costs) (40). The authors estimated a reduction in households' private health insurance costs in 1993, the first year of plan implementation, of \$6.0 billion. According to the authors, the analysis was based on an earlier draft of an analysis of a Managed Competition proposal by Sheils and his colleagues (41). Long and Rodgers' estimate assumed the implementation of universal coverage and Managed Competition, and further assumed savings from Managed Competition of 8 percent, based upon the experience of group-model health maintenance organizations or, in the alternative, upon the reduction in the administrative costs for employer plans (40).

It is important to note that the impact of a Managed Competition approach or proposal on households' *total* health care costs is an important factor in determining the reasonableness of the approach or proposal. To the extent that such costs are not even identified, the full impact of a proposal on households is hidden. Furthermore, assumptions about the extent to which components of Managed Competition (e.g., managed care, health insurance purchasing groups) will be adopted and effective in reducing health care costs are significant elements in estimating the economic impact of a proposal on households (as well as on other areas of the economy).

PER-CAPITA AND PER-FAMILY ESTIMATES

The estimates shown in table 4 (in chapter 1) and discussed above are limited to estimates of aggregate costs in billions of dollars. Other available estimates of the impact of the various reform approaches on households were calculated on a per-capita or per-family basis and are provided in appendix B. They range broadly and include:

- savings of \$102 per capita under a Single Payer plan with price controls (77);
- savings of \$1,382 for the average family under a Managed Competition plan with budget targets and price controls (3);
- increased spending, at least initially (i.e., before cost containment efforts could take effect) of up to \$672 by families with incomes greater than \$30,000 per year under a Play-or-Pay plan that would also increase provider reimbursement rates under Medicaid (37).

DISTRIBUTIONAL EFFECTS

Depending on the particulars of an approach or proposal, incomes of families of different income levels, compositions, and ages could be affected differently. One example is suggested in the illustration above (see "Per-Capita and Per-Family Estimates"): in addition to estimating that families with incomes greater than \$30,000 would

have to spend more under their plan, at least initially, Lewin-VHI, for the American Academy of Family Physicians, estimated that families with incomes under \$30,000 would, on the average, save from between \$2 to \$385 initially (37). In general, analyses that provided estimates by family income assumed greater health expenditures by families at higher income levels and lower health expenditures by families at lower income levels as a result of their plans (see appendix B). An exception is the Heritage Foundation plan, under which very low-income families would spend more than they do currently (35). However, the income 'cuts' were defined differently by different analysts, and so they make distributional effects even less comparable than the aggregate effects shown in table 4 and discussed earlier in this chapter.

SUMMARY

Any estimated effects on households should be taken with a large grain of salt. In addition to basic differences in estimates derived from differences in estimated national health expenditures under plans, analyses differ in the types of effects on households that they identify as pertinent. In addition to direct health care spending, these can include household income taxes, total employee compensation, and tax expenditures related to health care costs.

As suggested in figure 1 presented earlier in this report (see chapter 1), policymakers and the public should realize that, ultimately, American households-in the aggregate-will face all the costs of whatever national health care costs are incurred.⁹

⁹ Under this logic, and assuming that the estimates in table 1 in chapter 1 are considered valid, the estimates in table 4 in chapter 1 should be parallel to those shown in table 1, at least as household effects pertain to national health expenditures. That is, whatever health care savings are achieved or additional health care spending incurred should be attributed to the households of the United States.