Why "Play or Pay" National Health Care Is Doomed to Fail

By Stuart M. Butler, Ph.D.

Mr. Chairman, Senator Mitchell's HealthAmerica legislation, S.1227, would create a national health system in America on the "play or pay" model. In this approach, U.S. companies would be given a choice: either provide a minimum specified package of health benefits to employees and their families, or pay a payroll tax to finance a public program to cover Americans not covered under company plans.

S.1227 is often said to be compromise legislation. Proponents claim that it would establish a universal health care system by building on what we now have and incorporating some new features that are far short of the national health model characterized by Canada. Yet such a hybrid system would incorporate the worst features of today's employer-based system and the Canadian system, not the best. Moreover, I believe the system created by S.1227 would be politically unstable, and would degenerate quickly into a taxpayer-financed national health system. Thus Congress should be frank with the American people. It should debate the merits of a Canadian system. And it should debate the merits of a consumer-based universal health care system, such as that proposed by The Heritage Foundation, which is the real alternative to the Canadian model.[1] Then it should choose between these two principal options. It should not try to suggest that play or pay is a compromise. The play or pay approach of S.1227 is nothing more than a "stealth" Canadian model, because that type of system almost certainly will be the final result of enacting S.1227.

I would like to begin my comments on S.1227 by quoting from statements made by Senator George Mitchell, the Senate Majority Leader and principal sponsor of S.1227, when he recently testified before the House Budget Committee concerning his legislation. During his testimony, Senator Mitchell made the following astute observations:

> Many years ago, not by any grand plan or design to meet what was, in fact, an unmet need in our society, we began a process which has resulted in the separation of the payment for health care from the receipt of health care services. That has met, to some degree, what was an unmet need; but it has, at the same time, created overutilization and a problem of attitude with respect to the quantity of health care services.

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1 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Using Tax Credits to Create an Affordable Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of the American Medical Association*, Volume 265, May 15, 1991.

Stuart M. Butler is Director of of Domestic and Economic Policy Studies at The Heritage Foundation.

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> Consider this fact: In ours and every developed society, there has grown, in recent years, a very large industry based upon the simple premise that a person who can defer the payment for a good or service will purchase more of those goods or services. I confidently predict that almost everyone in this room has one or more credit cards in their pocket. It is a large and very successful industry, which operates on that simple premise: If we can defer payment, we will buy more of things. In fact, we do.
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> Imagine then, the effect on attitude if another person believes that they do not have to pay at all. If their attitude is, I am not paying anything for this, we readily, of course, are prepared to purchase more.
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> To some extent—and it ought not to be exaggerated—but to some extent, that is a factor in overutilization and the volume of services provided today.
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> ...I think we have to begin to change attitudes and convince every American that they are paying because, in fact, they are.

Senator Mitchell has, in my opinion, clearly identified the driving force behind many of the current problems with America's health care system, namely that the current system largely divorces the payment for health care from the receipt of health care services.

One group—beneficiaries—are concerned primarily with the receipt of health care services. But because they are insulated from the true costs of those services, they have little interest in those costs. Another group, businesses and governments, are concerned primarily with paying for health care. Since businesses and governments are merely legal entities, they do not use health care services, and thus have little natural interest in the quantity or quality of those services delivered to patients.

At the same time, under this system, providers naturally offer more services and seek to charge more for them. Normally, in the rest of the economy, this tendency would be constrained by consumers demanding the highest benefits at the lowest cost. But health care providers function in a very different environment from that faced by providers of goods or services in other areas of the economy. Providers elsewhere must constantly try to keep down the prices they charge if they are to survive. That does not happen sufficiently in health care because consumers generally have little incentive to challenge cost.

What is missing, then, from the current health care system is any effective mechanism for balancing costs with quantity and quality. There is simply no mechanism for seeking or obtaining good value—that is, the best quantity and quality at the best price—for either Americans as individuals or society as a whole.

Two Remedies. This fundamental defect in the existing system can be remedied in one of only two ways. Either the system must be changed to give those who benefit from health services direct control over the funds used to pay for those services—a consumer-led model—or it must be changed in the opposite direction by eliminating the ability of consumers to demand services without regard to cost. This latter result is accomplished by giving control over the supply of health care completely to government officials who can ignore the excessive or inefficient demands of consumers. These are the only two ways effectively to solve current problems in the health care system. A hybrid system, epitomized by play or pay proposals such as Senator Mitchell's bill, is not in fact a compromise between these alternatives. In practice it would com-

bine the worst features of each approach and would be economically damaging as well as politically unstable.

The first approach I mentioned—the consumer model—necessitates sweeping reforms based on consumer choice and market principles to give individual Americans and their families direct control over the funds used to buy their medical care and health insurance and the incentive to use funds efficiently. Such reforms would be accompanied by some structure of direct subsidies, through the tax code or direct assistance, to provide lower-income or chronically sick individuals with the extra funds they require to purchase needed medical care and health insurance roughly equal to that of the rest of the population. This is the approach which I, among others, advocate.

The second approach also necessitates sweeping changes to eliminate the problem that consumers, facing perverse incentives, are not encouraged to use health resources efficiently, or even effectively. These changes would grant government complete and direct control over the system, including the key economic levers of price, quantity, and quality, through a national health insurance program. Such a program could be structured along the lines of either a public service model, such as the British system, or along the lines of a closely regulated public utility model, such as the Canadian system. Various individuals, including some members of Congress, advocate this type of approach. I do not agree with this approach, but it *is* the only logical alternative to a consumer-based system.

No Third Choice. I do not see any third choice. Specifically, I do not see how pursuing any course of reform, other than the two choices I have described, will result in a system that is politically or economically workable. Trying to pursue a third way that is based on neither of these fundamental options, or is an attempted combination of the two, will only create a more unstable and ineffective system—leading to eventual reform in one of the two directions I have outlined. The effect of such a measure will be only to delay the inevitable day of final decision.

Unfortunately, Senator Mitchell and others, including the Chairman and some members of this committee, have chosen to pursue that unworkable third approach in S.1227.

The basic elements of S.1227 are:

1) The establishment of a federally-defined basic minimum package of health insurance benefits for all Americans.

2) A requirement that employers either purchase health insurance coverage for their workers and dependents from private insurance companies, which meets or exceeds the federally-defined minimum, or pay a new payroll tax to fund government-provided health insurance for their workers and dependents.

3) Strong anti-discrimination measures to stop employers who offer insurance from firing or refusing to hire individuals whose families might mean high costs for the firm's health plan.

4) The replacement of Medicaid with a new public assistance program providing health care coverage to all Americans lacking private, employer-provided insurance.

5) A new set of regulations and restrictions on how private health insurers write policies and conduct business.

6) The creation of a new mechanism of government-sponsored negotiations and government-imposed regulations designed to control the quantity, quality, and cost of health care services throughout the entire system.

While there are differences in the details, S.1227 is no different in basic structure from other proposals based on the concept of health care reform commonly known as the "play or pay" approach.

Rather than presenting a detailed analysis of S.1227, I will, in the rest of my testimony, comment on what I see as the major flaws of this legislation and of all similar play or pay proposals. I do this because over the long haul the details of a particular bill actually are of marginal significance. The eventual outcome will be driven by powerful pressures emanating from the fundamental dynamics of play or pay.

The premise of the play or pay approach is that because the majority (over 80 percent) of American workers and their dependents currently receive health insurance coverage through the work place, the ideal way of creating a universal health care system would be for those who currently lack health insurance to receive coverage in the same manner. The conclusion, based on this reasoning, is that employers not now providing these benefits should be forced either to provide coverage by private means (that is, "play") or fund the cost of government-administered coverage (that is, "pay"), for uninsured workers and their dependents.

Major Consideration. Some lawmakers and policy makers assume that the absence of universal employer-sponsored coverage is due to a desire to freeload on the part of some employers. This is largely wrong. Surveys show that workers consider the existence or absence of employer-provided health insurance to be a major consideration when choosing a job, and that employers feel competitive pressure to offer health insurance as a means of attracting or retaining workers. The main reason most uninsured Americans lack health care coverage is that they and/or their employers are unable to pay the cost of a reasonable health benefits package. One major reason for this is that the current tax policy designed to give an incentive for employers to provide insurance is inequitable and contains highly perverse incentives that push up costs.

For employees, the only way to obtain significant assistance towards health care costs, short of going on welfare, is through the exclusion for company-provided plans. This provides generous tax relief to employees in high tax brackets and least help to workers in the lowest bracket. If the employee works for a small firm without a plan, he or she usually must pay for insurance or care in after-tax dollars. Thus the design of assistance is exactly the reverse of the principle of providing most help to those who need it most. In addition, many workers see employer-provided coverage as "free" to them and have little incentive to economize, especially if it is first-dollar coverage. And insurance at the place of work means that the coverage is not portable—thus many employees with medical problems either are unable to move to a better job or face a financial catastrophe if they are without work even temporarily.

For businesses, the cost of covering employees includes not only the cost of insurance premiums but also the substantial, hidden administrative costs imposed by government regulation of employee benefits plans. These administrative costs explain why some businesses do not offer insurance to short-term employees, even if they are otherwise highly compensated. It is also a major deterrent to small businesses (where most uninsured workers are employed) offering insurance. Furthermore, group insurance through the place of work means higher overhead costs for small businesses.

The effect of a play or pay scheme, such as that in S.1227, thus would be to force employers or workers who cannot afford health insurance to buy it anyway (either privately or through the government), with money they must take from somewhere else.

The play or pay approach is also premised on the fallacious assumption that there is no difference between an incentive and a mandate. A government subsidy, such as the current tax exclusion for employer provided insurance, helps people to buy the goods or services in question. The magnitude of the subsidy will determine how many people are induced to purchase and to what degree. In contrast, mandates give no assistance—only an obligation. Thus people seek to evade mandates, or limit their effects.

Given that the existing incentive of a tax subsidy for employer-provided insurance results in coverage for over 80 percent of the population, the better way to provide coverage to the remaining population would be by reforming existing tax subsidies. In that way, existing tax assistance could be targeted more to those who really need it—especially those who are not employed in large firms and those who move often between jobs.

A play or pay system, on the other hand, will have significant economic and political implications of a very different kind. These will be economically damaging, and will cause the health system created by S.1227 to be politically unstable. Among them:

1) There will be incentives to avoid hiring employees with potentially high medical costs and to dump such workers on the public plan.

The Mitchell bill will create a perverse incentive for businesses currently providing health insurance to drop coverage for some or all of their workers. The employment effect of an employer mandate was referred to recently by the Congressional Budget Office, in its July 1991 report, *Selected Options for Expanding Health Insurance Coverage*. According to the CBO:

> Some employers might reduce their work force by laying off workers or by reducing the hours of those who remained employed. In addition to reducing the number of full-time workers, firms would have an additional incentive to restrict some workers to part-time work below the threshold in order to avoid the mandate altogether. This incentive would be particularly strong if a large proportion of a firm's workers were near the threshold set by the mandate (page 39).

Moreover, regardless of the nature of the required basic plan, or the size of the tax imposed as an alternative to providing insurance, play or pay will set in motion an unintended cycle of adverse selection and employment discrimination. All businesses whose health benefits are comparable to the government plan, but whose costs exceed the payroll tax, will have an incentive to pay the tax and assign their employees to the government plan.

Raising or lowering the amount or percentage rate of the tax will only compound problems in one direction or another. The lower the tax, the greater the number of workers who will be dumped onto the public plan and the larger the deficit in the public plan. The higher the tax, the fewer workers will be dumped, but the greater will be the job losses, particularly for low-skilled workers.

Regardless of whether employers comply with a play or pay system by buying insurance privately or by paying the payroll tax to cover their workers under the new public program, the effect will be the same. Mandating extra employer-provided benefits, like increasing by law any other cost of hiring employees, depresses cash wages and/or reduces employment. Furthermore, the cost of those actions is borne not by employers but by the workers themselves, and the hardest hit are the lowest wage workers—the same ones who are most likely to lack health insurance.

While economists debate the extent of such job losses, there is no question that they will occur under a play or pay system. Before enacting such a system, I suggest that Congress stop to con-

sider the possibility that low-income families might consider a job to be more valuable than a government health plan.

2) Government will have to take ever tougher action to combat discrimination in hiring, likely resulting in most firms deciding to shift their employees to the public program and pressing Congress to adopt a more radical reform of the health system.

A play or pay system would not only give employers a strong, perverse incentive to dump costly workers and their families onto the government program, it would also give them a powerful incentive to avoid hiring workers whose families would be costly to insure. Quoting again from the CBO analysis:

> Employers forced to provide health insurance for the first time would have an incentive to discriminate against workers with high insurance costs. For example, an employer would prefer to hire a married woman who is likely to be covered by her husband's more generous policy instead of hiring a single parent with children (page 39).

S.1227 attempts to prevent such behavior through anti-discrimination provisions. These are tough measures, as they would have to be to stop corporations refusing to hire individuals who could impose enormous medical costs on employers. Let me remind you of these provisions:

> [Section 2712 (c)] "NONDISCRIMINATION BASED ON FAMILY STATUS - An employer shall not fail or refuse to hire, and shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child that would be required under this part to be enrolled by such employer in a health benefit plan."
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> [Section 2732 (a)(1)] "15 PERCENT OF WAGES - Any employer that does not comply with section 2712 (c)... shall be subject to a civil penalty of not more than 15 percent of the total amount of the expenditures of the employer for wages for employees in that year."
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> [Section 2732 (b)] "Any employer that knowingly does not comply with section 2712 (c)....shall be liable for damages (including health care costs incurred) to the employee or the family of the employee resulting from such failure to comply. Such an employee or family member may bring a civil action to recover damages resulting from an employer's failure to comply with such requirements."

It is clear that attorneys would earn good fees from such provisions, and that companies could face the prospect of potentially staggering damage claims from employees or would-be employees. Faced with this prospect—which could involve damage claims far in excess of anything likely under the proposed civil rights legislation—many if not most companies would tend to pay the tax rather than opt to insure their workers. The fact is that the potential cost of litigation not only would be large, but it would be uncertain. Thus opting to drop existing insurance and pay the tax would be a way for corporations to avoid that unknown potential cost and settle for a known cost. Thus the "pay" element of the new system would grow while the "play" element would decline.

I suspect that if S.1227 becomes law, the reaction of many businesses who feel unable to cancel their current insurance package, perhaps because of strong union opposition, will be to press for Congress to get them out of their potential problem by enacting a comprehensive national health insurance program paid for out of taxation. Or businesses will demand that consumers, not businesses, be required to obtain medical plans and be granted tax relief to afford such plans.

In other words, I believe the play or pay model is politically unstable, and likely will evolve into one of the polar alternatives I discussed at the beginning of my testimony.

3) Play or pay will require steadily tighter and more sweeping price and volume controls, leading to a system indistinguishable from a government-operated national health system.

By legislating an arbitrary minimum benefit package that employers must provide, and an equally arbitrary tax they must pay if they fail to provide those benefits, the government would force firms that have kept their health care costs under the tax level to make up the difference or drop their coverage. Thus the system would punish the firms that have done the best job in controlling costs.

Nor do I think that the cost control provisions contained in S.1227 will prove effective. Without digressing into a lengthy and technical discussion of the likely effects of those provisions, I will simply observe that the present Medicare system has even more stringent price-setting authority than that proposed in S.1227 and yet it has not been able to control cost escalation.

Thus I believe once again the health system envisioned in S.1227 is inherently unstable and will evolve into something else, most probably a system more like the Canadian or British systems. As limited price-setting authority is found to be ineffective, the tendency will be for increasingly stronger price controls—and for steps to be taken to draw more aspects of the health system under government control, in order to avoid adverse selection against the government.

4) The "basic" benefits package will expand, raising the taxpayer cost of the public program and blunting current business-led efforts to control costs.

Mandating any minimum benefit package on employers would result in enormous constituency pressure on Congress to add more and more services under the mandated minimum benefit package, and to reduce its cost-sharing requirements on beneficiaries. This pressure would come from consumers desiring more "free" or "lower cost" services.

Medicare offers a good example of this kind of behavior. When the program was created in 1965, the out-patient deductible was set at $50. It has been increased only three times since then to its present level of $100. Yet, had the deductible kept pace just with general inflation it would today be $220. I strongly doubt that the provisions in S.1227 stipulating annual inflation adjustments in deductibles would last long under pressure from constituents to freeze or lower them.

Pressure would also come from providers initially excluded from the system. Having the government require people to buy your services is a great way to guarantee your income. There can be little doubt that Congress would also bow to this pressure. State legislators have already done so, enacting over 800 laws in the past fifteen years requiring insurers to cover specific providers or services—even when consumers expressed little or no interest in the benefits. The political and economic problem of state insurance mandates, which artificially increase the cost of insurance and medical care, would simply be transferred to the federal level.

These pressures would combine to undermine the current efforts of businesses to hold down costs by negotiating with organized labor and by redesigning health packages. Organized labor, perhaps understandably, would have the incentive to achieve increases in benefits through the political process rather than at the bargaining table. And provider groups similarly would turn to the political process when they feel excessively squeezed by employers trying to curb costs.

Some large businesses, with well paid workers and generous benefit plans, on the other hand view play or pay as a way to lower their own health care costs. Those businesses argue that their

health insurance costs are unnecessarily high because providers increase charges to their insured workers to cover the cost of providing free or low-priced care to the uninsured. They believe a play or pay system would shift those costs back to the employers who do not provide insurance.

Eliminating current health care cost-shifting in which the cost of treating the uninsured is added to medical bills paid by the insured is not, contrary to the arguments of some large businesses, a valid reason for adopting a play or pay system. If employers themselves paid for health insurance, there might be some justification to this argument. But they do not—employees pay for health insurance. Employee compensation equals cash wages, plus non-cash fringe benefits, plus payroll taxes paid by employers. Employees with tax-free employer-sponsored health benefits generally earn much more than workers without such benefits. Thus, despite the inefficiencies of a system in which those with employer-provided health benefits cross-subsidize those without such benefits, in reality it is a far more progressive "solution" than imposing an additional payroll tax on the uninsured, which would cut the cash wages of lower-paid workers.

5) Play or pay is regressive.

While the current tax exclusion for employer-provided insurance is regressive, with the benefits accruing disproportionately to the more affluent, that regressivity is partly offset by the informal system of cross-subsidies which funds uncompensated care for the low-income uninsured, who receive no tax breaks on their medical care. Replacing those cross-subsidies with a new payroll tax on low-income workers, as S.1227 would do, may be even more regressive since it would have the effect of reducing the compensation package for many workers and their families who now receive uncompensated care. I do not believe it is the intention of this committee or of Congress to fund America's health care system by taxing the poor. Yet, that is precisely what S.1227 would do.

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As I noted earlier in my remarks, I believe that the play or pay approach on which S.1227 is built is inherently and irredeemably unstable. It is unstable both in economic terms and in political terms.

It will not control health care costs. It will cause many Americans to lose their jobs. It will encourage discrimination against potentially high cost applicants for jobs. It will trigger an avalanche of costly litigation. It will set in motion a cycle of public and provider demands for lower copayments and more covered services. It will be regressive, penalizing low-income American workers with a new payroll tax. It will depress cash wages. And the payroll tax mechanism eventually will force Congress to chose between the two fundamental options I outlined at the beginning of my testimony.

If the payroll tax is set high, then a largely private system will be preserved, but at a cost of greater unemployment, business failures, and reductions in cash wages. If Congress tries to ameliorate those adverse consequences by extending or expanding the tax relief contained in S.1227 or other offsetting subsidies to businesses and individuals, it will be a day's march closer to the private, consumer-oriented approach I advocate.

If, however, the payroll tax is set low, then an increasing number of Americans will be dumped into the public plan and Congress will be a day's march closer to the national health insurance system advocated by others.

In the final analysis, there is a certain inherent logic to a consumer-oriented, market-based system. There is also an inherent logic to a government-based, national health system which replaces the consumer-based market with government allocation of resources and government as-

sessment of value of benefits. However, there is no inherent logic to an employer-based system or to a play or pay system of employer mandates.

As Senator Mitchell noted, our present system is the product of historical accident and not design. In light of the problems it has generated, Congress should avoid extending this system through a play or pay system. There is every reason to replace it with one or the other of the two fundamental systems I have described. I urge this committee and Congress to make that fundamental and necessary choice now, rather than later.

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