

**Statement of Professor Jonathan Gruber
For “Health Reform Summit 2008”**

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Thank you for inviting me to join you in this important “kick-off” event to the debates over health reform that will be so important in the next year or two. I would like to address my comments to the role of employer-sponsored insurance (ESI) within the context of health reform. As we all know, ESI is the predominant source of health insurance coverage for Americans. One-hundred sixty million Americans, or 62% of the non-elderly population, obtain their health insurance coverage through the workplace. But this source of insurance provision is becoming increasingly unreliable. Just six years ago, 68% of the non-elderly population obtained their insurance from employers, for a decline rate in ESI coverage of one percentage point per year. Roughly half of the decline in ESI has been absorbed by growing public insurance rolls, but another half has been reflected in a rising rate of uninsurance. This disturbing trend puts the role of ESI front and center in any discussion of reform of the U.S. health care system.

Any effort to realistically address the problem of the uninsured in the U.S. must involve some mechanism for pooling their risks. Unpooled risk in the non-group market has proven an expensive and unreliable means of addressing uninsurance, and as a result the number of uninsured is triple the number of individuals buying non-group insurance. For the past sixty years, employers have proven to be a natural pooling device for the purchase of insurance, but that pooling device is eroding.

ESI has some advantages as a pooling mechanism: individuals come together to work for reasons other than health, so for sufficient group size insurers can reasonably predict expected expenditures, insurance premium payments can be readily administered through payroll systems, and large groups imply lower administrative costs. But an employment-based system has some disadvantages as well. It is incomplete, leaving both those who are unemployed and those who work for the smallest firms without a reliable source of insurance pooling. And it distorts the labor market, as individuals can be “locked” into their jobs for fear of losing insurance.

It is also important, before discussing any policy alternatives, to dispel a key myth about ESI: that the costs of ESI are paid by employers and not employees. Both theory and evidence show that, ultimately, the costs of ESI are paid by employees in the form of lower wages. This is important to understand because it undercuts a common argument heard for propping up the ESI system: to “keep employer dollars in the game”. In fact, all this system is doing is keeping *employee* dollars in the game. The most important argument for maintaining our ESI system is that it is a means of pooling health risk that has worked for many years to provide comprehensive insurance to the majority of our population. The concern with eroding ESI should not be about employers getting a “free ride”, but about employees losing access to a means of buying fairly priced insurance.

So what is to be done? There are essentially three directions for policy makers as they consider the role of ESI in a reformed system:

Option 1: Try to bolster ESI through a “pay or play” approach

The first option is to attempt to buck the trend towards declining ESI by incorporating into any plan a “pay or play” structure, whereby employers who don’t offer ESI (or spend at least some threshold percentage of payroll on ESI) pay a fee which is equal to the threshold payroll percentage. Such a structure would have two advantages. First, it would be a natural source of financing for a plan. A rough estimate is that a pay or play system with a six percent threshold could raise \$40-\$50 billion/year, depending on the other elements of the reform plan. Second, it would bolster the ESI system, mitigating the trend away from ESI, and also reducing the pressure to opt out of ESI that may be put in place by other elements of reform. At the same time, a pay or play system by itself will not cover the majority of the uninsured, because (a) many uninsured are unemployed, (b) many firms would rather pay the fee than offer and (c) some employees who are offered insurance will choose to turn it down.

Option 2: Put in place alternative pooling mechanisms

The second option is to put in place alternative pooling mechanism for individuals without access to ESI. An example of such a mechanism is the Commonwealth Care program put in place by the state of Massachusetts, which makes highly subsidized insurance available to any individual below three times the poverty line if the person is not offered ESI. This mechanism has the advantage of being universal so that any individual without ESI can access the system. As such, it is a necessary component of any universal coverage plan given the holes in ESI availability.

At the same time, such a mechanism will likely serve to erode ESI, as employers stop offering insurance to enable their low-income employees to take advantage of the subsidized low-income pool. The exact amount of erosion is uncertain, and depends on the generosity of this new alternative as well as the share of a firm’s workforce to which it applies. But the direction is clear: such a system by itself would further lead to erosion of ESI. This is the fundamental conundrum of health reform: trying to fill in holes in the existing system will cause some to want to jump into those holes.

Of course, there are ways to minimize the erosion of ESI due to any such alternative pool. One means of doing so is combining the new pool with a pay or play requirement. Another is to combine it with an *individual mandate*. An individual mandate will reduce erosion of ESI offers as employees demand that their employers help them meet the mandate; it will also increase ESI coverage by inducing enrollment among those now eligible for ESI but not enrolled. Encouraging evidence on this front comes from the state of Massachusetts, which put in place a low-income pool without a very substantive pay or play requirement – but with an individual mandate. In the first year of reform, the number of residents with ESI *rose* by an estimated 85,000, flying in the face of declines in ESI nationwide.

Option 3: Reform the tax exclusion to ESI

There is much discussion in Washington about unsustainable growth in entitlement programs, in particular the major government health programs Medicare and Medicaid. Yet there is equally rapid growth in the third largest, yet rarely discussed, government entitlement for health care: the exclusion of employer-sponsored insurance expenditures from individual taxation. When MIT pays me in wages, I pay tax on those wages. Yet when MIT provides me with the roughly \$10,000/year in health insurance expenditures that they cover, I don't pay taxes on that compensation. This inequity between the treatment of these two forms of compensation, wages and health insurance, currently costs the U.S. government over \$225 billion/year in lost tax revenues.

The tax exclusion of ESI expenditures has three flaws. First, this is an enormous sum of money which could be more effectively deployed elsewhere, especially through alternative approaches to increasing insurance coverage. Second, this is a regressive entitlement, which higher income families gain more both because they are more likely to have ESI, and because their tax rates (and thus the tax subsidy) is higher. Third, this is an inefficient subsidy which makes health insurance artificially cheap relative to other consumption goods. This leads some individuals to buy excessively generous insurance coverage through their workplace, leading to insensitivity to health care prices and a rising spiral of health care costs. As result of these limitations, no health expert would ever set up a health system with such an enormous tax subsidy to a particular form of insurance coverage.

Yet the existing system is predicated on this tax exclusion, so policy makers must be wary about simply removing it. Many employers currently only offer health insurance because of this "tax bribe", and ending the exclusion would lead to a large erosion of ESI. Without some other health insurance alternative (e.g. the type of alternative pooling mechanism described above), many individuals losing ESI would end up uninsured, particularly those in poorer health who cannot get coverage in the non-group market. The exact size of the erosion of ESI is unclear, but it is the uncertainty that is worrisome. Given that the number of individuals with ESI remains over three times as large as the number of uninsured, even a small ESI erosion would imply a large rise in the share of the population uninsured.

This leaves policy makers with two alternatives in terms of reforming the ESI exclusion. The first is to pair this with some alternative form of insurance pooling. Removing the exclusion entirely and allowing individuals to buy their insurance through an alternative pool (subsidized through a reinvestment of the savings from the exclusion into a more progressive approach such as refundable tax credit) would lead to a large erosion in ESI, but *not* necessarily any erosion in the total number of covered lives. The other is to move more slowly towards a limited reform of the exclusion rather than outright repeal. For example, ESI expenditures could be excluded from taxation up to some threshold level (e.g. the median level of ESI expenditures), and taxed only above that level. Such a "capping" approach should not lead to much erosion of ESI, and it

would not raise nearly as much as would full repeal, but it would reduce the incentives for overly generous ESI plans. On the other hand, those impacted by such a cap would not only be individuals with the most generous plans, but also individuals who are in high cost states, or who work in workplaces with high cost workers.