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My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. Thank you for giving me the opportunity to speak today about the important role that the way we finance health care plays in shaping the extent of health insurance coverage and the quality of the health care that we receive.

Our health care system faces several related challenges. The number of uninsured people in America is nearing 50 million. Coupled with this is a dramatic increase in health care spending, with health care comprising a rising share of both GDP and public budgets. These two trends are not unrelated: as health care costs rise, it becomes increasingly difficult for families to afford insurance. As more people become uninsured, public and private resources devoted to their care are stretched thin, resulting in less efficient care and worse health outcomes. The goals of controlling costs and increasing insurance coverage should thus go hand in hand.

Perhaps even more important than reducing costs, however, is increasing value: there is ample evidence that we do not get as much value from the health care system as we should. While much of the care delivered in the U.S. is of immense value to those receiving it, a not insubstantial share is devoted to intensive, expensive care with questionable health benefits. Proposals aimed at reducing costs should focus on reducing the use of care of such ineffective care, while ensuring the wide availability of high-quality, high-value care.

What steps could be taken to increase the value of care received throughout the health care system while promoting broader insurance coverage? One of the culprits in driving inefficient use of health resources is the current tax treatment of health insurance. Reforming this treatment, in combination with other policies, could be a crucial step in moving towards a system with higher value and more broadly accessible care.

THE CURRENT TAX TREATMENT OF HEALTH INSURANCE

Health insurance purchased through an employer is not subject to taxation, while health care purchased through the individual market or out-of-pocket for the most part is (although there are exceptions). This means that the cost of obtaining health care through an employer policy is substantially lower and that first-dollar policies are subsidized relative to other levels of cost sharing, as the following examples may help illustrate.

- Amy works for a salary of \$50,000 but does not receive health insurance through her job. She spends \$10,000 on health care (including both a premium for an individual market insurance policy and out of pocket costs).
- Barbara works for a salary of \$45,000, and her employer pays a \$5,000 premium for a basic policy that leaves her with \$5,000 in out of pocket costs.
- Carol works for a salary of \$40,000 and her employer pays \$10,000 for a comprehensive insurance policy that covers all of Carol's care (leaving her with no out of pocket costs).

Each of these women receives \$50,000 in total compensation, and for each \$10,000 is devoted to health care costs, but they would have very different tax bills. If they are in the 15 percent income tax bracket and paying about 15 percent in payroll taxes (total of employer and employee shares), Barbara would pay about \$1,500 more in taxes than Carol, and Amy would pay about \$3,000 more than Carol. The exclusion is worth more to people in higher tax brackets. This regressivity is compounded by the fact that higher income people are more likely to have insurance through their jobs, while lower income people are more likely to be uninsured and thus have no tax benefit.

As an aside, it is worth noting that because each of these employees receives the same total compensation, employers are roughly indifferent about which package they offer. (The employer pays taxes neither on wages nor other benefits paid to employees, and that would not change in the reform proposals discussed below. The bias discussed here refers to the fact that employees pay payroll and income taxes on wages, but not on the premiums contributed by the employer.) Insurance is not a gift from employers: employees ultimately pay the cost of higher benefits in the form of lower wages. It is for this reason that the cost of employer mandates is ultimately borne by workers in the form of lower wages (and, in the case where wages cannot sink, potentially by reduced employment). Of course, many other factors affect employer costs of offering insurance and the subsequent effects on employment, and reform packages must be considered in their totality.

The net effect of this bias in the tax code is that because Amy does not have access to an employer policy, she in effect has to pay a higher price for her health care. This provision of the tax code is one of the factors that helped create our employment-based private health insurance system. It also drives higher spending on health insurance relative to other forms of taxable compensation (like wages).

A more subtle effect of this subsidization of employer-sponsored insurance policies relative to other forms of compensation like wages is that first-dollar insurance policies are favored relative to more basic policies with higher cost sharing. Suppose the cost of a

routine physician visit is \$100 and that everyone goes to the doctor once per year. An insurance policy that fully covers one physician visit per year will have a premium that fully reflects that cost plus some administrative fees – say \$105 more than a policy that does not cover that first visit. Most people would not choose to have insurance cover the visit in that case (much as auto and homeowners insurance do not cover routine maintenance) – but this is not the tradeoff that people with employer-sponsored insurance face. Because the premium for employer-sponsored insurance is paid with pre-tax dollars, someone in the 30 percent marginal tax bracket would in effect only pay about \$71 for the visit (in the form of higher premiums), compared with \$100 if it were not covered. This makes health insurance with higher premiums and lower copayments much more appealing.

Insurance plans that seek to lower premiums by increasing cost-sharing are thus at a disadvantage relative to plans that seek to lower premiums by other methods because much out-of-pocket spending is paid with after-tax dollars. This promotes plans with first-dollar coverage that may deliver very high-value care on average, but also foster the use of low-value care on the margin. Carol is likely to consume more health care than Barbara or Amy. Much of this extra care may have high value – with health benefits that are far greater than the cost of the health resources – but some may have limited value, and neither Carol nor her physician will necessarily consider the cost of the resources used if the health care has even the potential for a very small positive effect on Carol's health.

REFORMING THE TAX TREATMENT OF HEALTH INSURANCE

There are several ways that the tax code might be reformed to “level the playing field.”

- The tax exclusion for employer-sponsored insurance could be extended to all health spending. This would eliminate the bias against individually-purchased insurance and in favor of first-dollar coverage, but would leave in place a preference for health spending relative to spending on other things (like food and housing). Whether this is a good thing or a bad thing depends on whether we are consuming too much health care on average now or too little. In all likelihood we are doing some of each.
- The tax exclusion could be capped, so that premiums for employer-sponsored plans above a certain threshold would be taxed. This would eliminate the incentive to consume more insurance above the cap, but would leave intact a preference for employer-sponsored insurance below the cap relative to individually-purchased insurance and out-of-pocket costs.
- The tax exclusion could be replaced with a revenue-neutral “flat” tax deduction or credit available to anyone covered by at least a minimum insurance policy. In the

example above, Amy, Barbara, and Carol would all pay the same taxes. This would eliminate the preference for employer-sponsored insurance. It would also eliminate the preference for health spending above the minimum policy relative to spending on other things and the preference for low copayments, while maintaining a strong incentive to have insurance coverage.

There are of course many other reforms that are possible. I will focus the rest of my discussion on the pros and cons of this third class of reforms.

Advantages of replacing the current exclusion

Replacing the current exclusion with a flat tax benefit that was tied to having insurance would create a strong incentive to be covered by insurance (the extensive margin), while eliminating the incentive to have more generous insurance or insurance of a particular form (the intensive margin). This flat benefit could be structured to be revenue-neutral and to be more progressive than the current exclusion.

Higher-value care

If particular forms of health insurance were no longer favored by the tax code, there are several changes in the type of insurance that might be available and the type of policies that people would be likely to choose. In the short run, when health insurance and wages are on equal footing, people may opt to change the mix of compensation. In the longer-run, putting different types of insurance policies on equal footing (coupled with other reforms) may foster greater innovation in insurance products and longer-run contracts in the individual health insurance market. Such longer-term contracts could help promote near-term investments in health care that would minimize long-run health costs, such as multi-year contracts, disease-management plans, portable plans, or novel co-payment structures (such as subsidization of high-value care – even paying enrollees to get flu shots – coupled with higher copayments for lower-value care). The improved value that such a reform could deliver could be felt throughout the health care system.

This also highlights the importance of tying the tax benefit to having a basic insurance policy only, rather than to a particular form of insurance or to a benefit-rich policy: structured this way, the tax benefit could go much further in ensuring that all Americans can afford the protections that insurance provides. This would make the tax benefit both more progressive and more effective than the way these substantial resources are used in our current system.

Insurance coverage

Insurance markets function best when risk is pooled across many people. Tax policy can promote greater participation, whether through “carrots” or “sticks.” Replacing the

current tax exclusion with a flat credit or deduction could result in many more people being covered by insurance, although the number depends on many factors that are hard to measure. Those who are currently uninsured would receive a new tax benefit that would substantially lower the cost of insurance. Many (but not all) of them would likely take up insurance as a result. The flat credit would be more redistributive than the flat deduction, and would thus likely increase insurance coverage by more. This increase in take-up among the currently uninsured might be partially off-set by decreases in employer insurance coverage. The potential for employer erosion poses a serious transition problem that should be addressed.

Risks of replacing the current exclusion

It is unlikely that anyone designing a health system from scratch would tie insurance to employment (thus hampering labor market mobility), and would design a subsidy that accrued primarily to those with the most expensive policies and the highest incomes. Nevertheless, because that is the system that has been in operation for decades, most of the risk-pooling that occurs in insurance markets works through employer groups. While this does not mean that it is worthwhile to hold on to the current employment-based system at any cost, any reform of that system should be considered in light of the potential threat to risk-pooling and take steps to mitigate that threat.

There is an existing trend, particularly among small employers, away from offering health insurance. Leveling the playing field between individually-purchased and employment-based insurance could accelerate this trend. The magnitude of this effect is not clear (because employers offer a valuable service in selecting and bargaining with insurers, so jobs with insurance are liable to continue to be preferred by employees), but the basic mechanism is likely to operate in at least some cases. Reform proposals that favor the individual market over the employer market, such as tax credits or vouchers that could not be used in the employer market, would likely have a much larger effect on employer offering.

This suggests that extra attention should be devoted to the effect of such reforms on high-risk populations currently covered by cross-subsidized group policies. When people leave one group for another (or for the individual market), their current expected costs will be reflected in their premium upon entering the new market. While a comprehensive reform package could create such a system where all people obtain insurance while healthy, during the transition to that system some risk pools might dissolve as others formed. Sick people who had been in a group in which their risk had been pooled with other healthier enrollees would face the prospect of higher costs when their new premiums were determined. Members of this population, particularly if low-income, would need special assistance. That assistance should be thought of as a transfer program (another form of social insurance), not as health insurance, since the risk of poor health would already have been realized. While providing this assistance is a crucial

component of the equity of any reform proposal, insurance systems should be designed around generating risk-sharing with important complementary transfers handled separately.

Ensuring that those in the individual health insurance market will have access to stable insurance policies with premiums *that do not rise based on their health status* likely requires additional insurance market reforms. These reforms could be further complemented by policies such as risk-adjusted vouchers to subsidize the purchase of insurance for low-income, high-risk groups. These vouchers could be self-financing, and would promote insurance across a wider range of enrollees while encouraging cost-effective coverage. Other market reforms to promote continuity and stability of coverage would make credits more valuable to people taking them to the non-group market. A detailed discussion of these complementary reforms is beyond the scope of this testimony, but they would be crucial to the success of an overhaul of the tax treatment of health insurance.

CONCLUSION

Many policy-makers share the goal of creating a system in which everyone is covered by an affordable health insurance policy that delivers high-value care, and share the belief that our current system does not achieve that goal. Most economists would agree that our current tax treatment of health insurance is an important part of the problem, and that reforming that system would be a key component of a broader solution. Reforms that promote both broad coverage and high-value care can foster innovation and quality and help our health care dollar go further.