

Statement of Professor Jonathan Gruber

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Thank you for inviting me to testify today on the sources of financing for health care reform. The Congress is presented with a terrific opportunity to provide universal health care coverage to all Americans. But it also faces a major stumbling block in financing that coverage.

There is an inescapable logic of reform that lies behind the search for financing sources. First, moving to universal coverage is now acknowledged to require a mandate on individuals to have insurance coverage. Second, such a mandate is inhumane without subsidies to make health insurance affordable for lower income individuals. Third, these subsidies will require a large amount of new financing, on the order of one trillion dollars or more over the next decade.

How can the government finance such a massive new expenditure? There are a number of possible sources. In my testimony today I will move briefly through several of them, and then focus on the best candidate: reforming the tax subsidy to employer-provided health insurance.

In particular, I would highlight five “classes” of revenue sources for financing universal coverage:

Cost Control: The first is reductions in existing government spending on health care through cost controls. President Obama proposed over \$300 billion of such cost controls in his budget. The advantage of this source of financing is that it is well-matched to the budgetary needs of the program: savings from medical cost controls rise at the same rate as the spending required under this new program. The disadvantage of this source of financing is that the major approaches to controlling costs, such as greater use of disease management or medical homes, have yet to demonstrate large reductions in medical spending. As a result, it is difficult to find substantial savings from cost controls beyond those proposed by the President.

Sin Taxes: The second is increased taxation of “sin good” whose use raises the cost of health care for all Americans. This would include cigarettes, alcohol, and high sugar or fat foods that cause obesity. There is a strong public policy argument for raising taxes on all of these goods. In particular, the tax rate on alcohol is well below the level that would account for the damage that drinking does to society, in particular through drunk driving. Yet it is difficult to raise sufficient revenues from these sources, and these revenues will not rise at the rate of health care spending; indeed, they are likely to fall over time if we move the population towards healthier lifestyles.

Provider Assessments: Hospitals in the U.S. currently spend over \$30 billion/year on uncompensated care. Best estimates suggest that two-thirds of that amount is due to the uninsured. Thus, as we move towards universal coverage, there is a sizeable bonus to

hospitals that could be recaptured to finance insurance subsidies; indeed, moving money from back end care of the uninsured to up front subsidies to insurance was the notion behind the Massachusetts reform. Once again, this is a well-matched source of financing as it rises with hospital revenues. On the other hand, this is once again a fairly small source of financing.

Outside Sources: Another alternative is to turn to sources that are not health care related. For example, President Obama proposed that the ability of high income families to itemize their deductions be limited, raising over \$300 billion over the next decade. Income taxes could be increased in many other ways as well to finance health care reform. Alternatively, new sources of revenues could be found, such as a Value Added Tax or revenues from a carbon cap-and-trade system. While there are many options here, they all suffer from the problem noted thus far, which is that the revenues will generally rise at some rate slower than the rate of growth of health care premiums, so that ever increasing tax rates will be required to finance universal coverage.

This brings us to a final source of revenues, which is the exclusion of employer-sponsored insurance (ESI) spending from individual income taxation. This is both the most natural source of financing for health care reform, as well as one of the few that is clearly large enough to finance the subsidies needed for reform. I will devote the remainder of my testimony to discussing this important financing source.

We all know the two largest government health insurance expenditures, on Medicare and Medicaid. Less well known, and even less well understood, is the government's third largest health insurance expenditure: the \$250 billion/year in foregone tax revenues from excluding employer expenditures on health insurance from taxation. When MIT pays me in cash wages, I am taxed on those wages. But the roughly \$10,000 that MIT will spend this year on my health insurance is not taxed, amounting to a tax break of about \$4000 to me. To be clear, this exclusion is a tax break to individuals, not to firms; firms are indifferent between paying me in wages and in health insurance. But I am not indifferent about getting paid in wages or health insurance; I pay taxes on the former but not the latter.

The tax exclusion of employer expenditures from individual taxation has three flaws. First, \$250 billion/year is an enormous sum of money which could be more effectively deployed elsewhere, especially through alternative approaches to increasing insurance coverage. Even if we consider just the income tax exclusion, ignoring the payroll tax component, \$2.3 trillion in federal revenues will be lost over the next decade through this subsidy to employer-sponsored insurance. Second, this is a regressive entitlement, since higher income families with higher tax rates get a bigger tax break; about three-quarters of these dollars go to the top half of the income distribution. Third, this tax subsidy makes health insurance, which is bought with tax-sheltered dollars, artificially cheap relative to other goods bought with taxed dollars, leading to over-insurance for most Americans.

As result of these limitations, *no health expert today* would ever set up a health system with such an enormous tax subsidy to a particular form of insurance coverage. So why don't we just remove it? There are four counterarguments to using the exclusion as a financing source. I review each in turn:

Administrative Difficulties: Some have argued that it would be administratively infeasible to reduce this tax subsidy. This is simply wrong, as the process of including ESI spending in individual income taxation is quite straightforward. Employers would simply report the amount of their spending on an individual's insurance on that person's W-2 form. If the employer buys insurance, the premium is provided directly by the insurer; if the employer is self-insured, they simply use the premium amount they are required to calculate for COBRA purposes. If the exclusion is capped, rather than removed (as discussed below), then individuals would simply pay tax on the difference between the reported premiums and the cap.

Erosion of ESI: The existing predominance of employer-sponsored insurance 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 employer-sponsored insurance.

There are two reasons why this might be a problem – one is wrong and one is right. The one that is wrong is the concern that we will "lose employer dollars" when ESI erodes. Both economic theory and a large body of economic evidence show that *there are no employer dollars*: the money that employers spend on insurance would otherwise just be spent on worker wages. If MIT stopped offering insurance, over a several year period my wages would rise by \$10,000 to offset the lost insurance compensation, and MIT's bottom line would remain the same. The notions of "shared responsibility" or "keeping employers in the game" are political notions, not economic ones.

The right reason to worry about the erosion of ESI is that sick and older individuals are treated much more fairly in employer groups than they will be in today's non-group insurance market. Under ESI, all individuals pay the same for insurance regardless of age or health. But in most states those who are sick or older must pay much more for their non-group insurance, and in many cases it is simply unavailable. So as employer-sponsored insurance falls we could end up with a large new set of uninsured who cannot afford, or cannot obtain at any price, non-group insurance.

This is an important reason to be concerned about reducing the exclusion of ESI from taxation in a vacuum. But it is not an important concern when the policy is financing a broader universal coverage plan. In that case, individuals will face group rates on their insurance regardless of where it is purchased, and they will be subsidized if insurance is not affordable. Thus, any displacement from ESI will not lead to uninsurance, just a shift to a new exchange.

Middle-Class Tax Increase: The third concern raised about removing the exclusion is that it would be an across the board tax increase. As highlighted earlier, removal would represent a progressive tax increase, with 62% of the revenues raised from families with incomes above \$100,000 per year. Yet, there would still be a sizeable increase in taxation for middle income families, with 10% of the revenues coming from families below \$50,000 in income, and 28% from families with \$50,000 to \$100,000 of income.

For this reason, and given that the entirety of revenues from removing the exclusion is not necessary to finance reform, we should focus our attention in reducing, rather than removing, the tax exclusion. The exclusion can be reduced, for example, by *capping* the amount of employer-sponsored premiums that are excluded from taxation, so that individuals are not taxed on premiums below some level (say the average value of ESI premiums), and pay tax only on premiums in excess of that level. This has the advantage of addressing the bias towards excessively generous insurance without raising taxes from those who have basic insurance. Moreover, this is more progressive than an across the board removal of the exclusion, since higher income individuals tend to have the more expensive insurance. This policy still raises non-trivial revenues from middle income taxpayers, however.

Alternatively, the exclusion could be reduced in an income-targeted manner, by scaling back the exclusion only for higher income groups. This could be designed to protect middle-income taxpayers from any increase in tax payments. There are many possible combinations of caps and income limits that could be used, with varying implications for revenues raised from limiting the exclusion.

Another important consideration is how caps and income cutoffs are inflated over time. Given the rapid rise in health insurance premiums, a cap level that is inflated more slowly than premiums will mean that the cap is eroding over time. For example, a cap at the average ESI premium that is fixed in nominal terms is equivalent to a complete removal of the exclusion over an 11-12 year period. On the other hand, a cap indexed to ESI premium growth would not erode at all over time, so that a cap that excluded the least expensive 50% of ESI plans would continue to do so over time. A cap that rises, but at a lower rate than ESI premium growth, would erode over time, but more slowly than with no indexing.

It is useful to consider some examples of possible tax exclusion policies to understand the magnitude of the dollars involved. For example, suppose the government were to cap the exclusion at the typical ESI premium (\$4700 single / \$12,800 family today), starting in 2012, and were to index that cap at the rate of growth of the consumer price index (so that the cap rose, but at a slower rate than premiums). Such a policy would raise \$500 billion by 2019. Even if this cap were indexed to premium growth, so that in every year the government taxed only premiums above the typical ESI premium level (with no erosion over time), the policy would raise \$360 billion over the 2012-2019 period.

There are considerable revenues to be raised even at higher levels of the cap. A cap at the 75th percentile of the distribution of ESI premiums, so that only the top quarter of most expensive plans would be subject to some taxation, would raise \$330 billion over the 2012-2019 period if indexed to the CPI, and \$220 billion over that period if indexed to premiums.

Alternatively, the government could consider a more progressive structure. Consider a policy that capped the ESI exclusion at the typical ESI premium, but only for families with incomes above \$125,000 per year. Such a policy would raise \$340 billion over the 2012-2019 period if the cap were indexed to the CPI, or \$240 billion in indexed to premium growth. Additional “brackets” could be added so that the extent of taxation varied further with different income levels.

Unfairness of Reducing Tax Exclusion for High Cost Groups: A final criticism of reducing the tax exclusion, for example through a cap on the amount that can be excluded from taxation, is that it is unfair to high cost groups, for example those in states with expensive insurance or who are in workplaces with an older workforce. A fixed national cap on the exclusion, for example, would raise much more revenue in Rhode Island (where average single ESI premiums are about \$7000) than in New Mexico (where those premiums are about \$3500).

But this problem is readily addressable by adjusting the cap to account for differences in underlying cost factors across firms. For example, the cap could be adjusted upwards in high cost states to mitigate the disproportionate revenue increase for those states. Of course, to maintain the revenues raised from the cap, it would also have to be adjusted downwards in lower cost states; alternatively, the adjustment could be one-sided (upwards for expensive states only) at the cost of some lost revenue.

Similarly, the cap could be adjusted upwards in firms with older workers (and potentially downwards in firms with younger workers). Employers know their workers' ages and it would be straightforward for them to compute an adjustment factor based on the ages of their workers that could be used to adjust the cap.

In summary, there are a variety of financing sources to which the Congress can turn to achieve the critical goal of universal health insurance coverage. It is clear to me, however, that one source of financing dominates the others: reducing the expensive, regressive, and inefficient subsidization of employer-sponsored insurance. Financing coverage expansions by scaling back the exclusion would be highly progressive and would reduce a major driver of overinsurance and excessive health spending in the U.S. This is truly a win-win solution to your problem, in that it reduces a fundamental flaw in our existing system of health insurance financing, while raising the revenues required to cover the uninsured.

Thank you again for allowing me to testify today and I look forward to your questions and to helping the committee further as you tackle these difficult issues.