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Improving American Health Insurance Markets: Accountability to Patients, Not Government

FDA & Health

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The views expressed are those of the author in his personal capacity and not in his official/professional capacity.

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Executive Summary

American health care is unlike any other good or service that we purchase. Anyone who has spent time on the phone with a hospital or physician’s office trying to understand what CPT code 99201 is,¹ or why your insurer didn’t cover the bill, can attest to this. Just imagine what would happen if Apple sent customers an “updated bill” demanding an extra \$200 for that shiny new iPhone. Unfortunately, too many Americans accept the status quo as a necessity, or write it off as being a flaw of *too little* regulation and too much capitalism.

As it happens, that couldn’t be further from the truth. American health insurance, as with health care overall, can best be described as capitalism without prices and socialism without budgets. Of course, the façade of it all gives the impression that health insurance is a free-for-all in which the sickest in society are thrown to the mercy of greedy insurance executives. Under the hood, however, is a complicated system of regulations upon statutes upon guidances upon rules. The end result is a system where health insurance doesn’t respond to the needs of patients, but rather to the dictum of bureaucrats and lawmakers in statehouses around the country and Washington, D.C.

I. Where We Stand Today

The greatest failure of America’s health insurance markets is simple to illustrate. In 2016, there were 272 million people under age 65. 155 million of them received insurance through their jobs. That means more than half of this group couldn’t simply pick up and change careers while keeping their insurance plan. 68 million received coverage through Medicaid, the state-federal insurance program for the poor.² Though Medicaid is “portable,” in that employment status doesn’t affect it, the program has often been described as a “poverty trap” and doesn’t appear to do much in improving health outcomes. A small chunk of the remainder received coverage through various other programs like the Indian Health Service. Only a small fraction – around 20 million people³ – purchased insurance individually either through the Affordable Care Act (ACA) exchanges, or through other vendors.

What that means, is that just about 7.5 percent of Americans under age 65 have insurance that follows them wherever they go, and is accountable to them. Job-based insurance answers to the whims of employers, and state and federal regulators. Medicaid doesn’t appear to serve the needs of

¹ This is the billing code for a new patient with relatively low diagnostic complexity.

² “Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO’s March 2016 Baseline” (Congressional Budget Office, March 2016), <https://www.cbo.gov/sites/default/files/recurringdata/51298-2016-03-healthinsurance.pdf>.

³ “First Half of 2016 Effectuated Enrollment Snapshot,” *CMS.gov*, October 19, 2016, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html>.

its recipients either, with research finding that beneficiaries would likely spend much of the money differently if given the option.^{4, 5}

But how did we get here, and what can we do about it? With over \$3 trillion spent annually on health care, most of it funded through so-called “third-party-payment” (health insurance), demanding accountability to patients should be a priority. And understanding how we got into this mess in the first place can help shine a light on how we might get out.

II. The Original Sin: Employer-Sponsored Health Insurance

If you ask someone on the street whether they have government-funded health insurance, most people will say “no.” Statistically, this simply isn’t true. Ignoring the pure government-funded insurance programs like Medicare, Medicaid, and others, the vast majority of Americans still receive a massive subsidy to help pay for their coverage. Some may balk at the claim that insurance that they spend good money on each month is funded by the government. This simply illustrates how ingrained this system has become.

Indeed, this often-ignored subsidy costs state and federal governments well over \$300 billion in reduced income and payroll tax revenue.⁶ It is the single largest tax expenditure at the federal level, with the next largest – lower tax rates for capital gains – coming in at \$93 billion.⁷

So how does this subsidy work?

It’s simple. When an employer pays an employee, it can come in many forms. Economists refer to this as “total compensation,” which incorporates all the fringe benefits and cash wages that an employer pays for or purchases on behalf of the employee. This includes things like paid time off, pension plan contributions, and health insurance. Normally, employers and employees would pay taxes on all of these benefits – after all, why should it matter if your employer pays you in benefits or in wages that are economically equivalent?

It just so happens that a little-known 1943 ruling set the stage for excluding all of these benefits from taxation. This came partly as a response to wage and price controls established in the midst of World War II through the 1942 Stabilization Act. With wage controls (which restricted how much employers could pay their employees), it became difficult for employers to attract new and better talent. In 1943, the War Labor Board ruled that these price controls do not apply to fringe benefits, which gave employers a loophole to raise total compensation without violating the Stabilization Act.

⁴ Amy Finkelstein, Nathaniel Hendren, and Erzo F. P. Luttmer, “The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment,” Working Paper (National Bureau of Economic Research, June 2015), doi:10.3386/w21308.

⁵ Oren Cass, “Over-Medicaid-Ed: How Medicaid Distorts and Dilutes America’s Safety Net,” *Manhattan Institute*, May 18, 2016, <https://www.manhattan-institute.org/html/over-medicaid-ed-how-medicaid-distorts-and-dilutes-americas-safety-net-8890.html>.

⁶ Jonathan Gruber, “The Tax Exclusion for Employer-Sponsored Health Insurance,” SSRN Scholarly Paper (Social Science Research Network, February 1, 2010), <https://papers.ssrn.com/abstract=1556130>.

⁷ “What Are the Largest Tax Expenditures?,” *Tax Policy Center*, accessed April 19, 2017, <http://www.taxpolicycenter.org/briefing-book/what-are-largest-tax-expenditures>.

In 1954, through an overhaul of the Internal Revenue Code, Congress continued down this path, including a provision that explicitly excluded health insurance benefits from income taxation.^{8,9}

With a stroke of the legislative pen, today’s regulatory system for health insurance system was created. Today, employer-sponsored health insurance is less expensive to offer than a dollar of wages. To understand why, consider the following example (illustrated in Table 1):

Table 1: Difference in Taxes Paid With and Without ESI		
	Worker 1 (no ESI)	Worker 2 (with ESI)
Total Compensation	\$50,000	\$50,000
Tax Bracket	15%	15%
Payroll taxes	15.3%	15.3%
Effective rate	28.1%	28.1%
Wages	\$50,000	\$40,000
Health Insurance	\$0.00	\$10,000
Total taxes paid	\$14,050	\$11,240
Post-tax compensation	\$35,950	\$38,760

Let’s say that total compensation comes to \$50,000 for a worker with an average income tax rate of 15 percent. Payroll taxes (employer and employee combined) used to fund Social Security and Medicare also come to roughly 15.3 percent. (Note: the effective rate is less than the sum of these two numbers, because the total rate is applied after deducting the employer share of payroll tax.) The employer can pay \$50,000 all in wages with no benefits. That means that total taxes paid (for both employer and employee) come to \$15,000. Net compensation comes to \$35,950, assuming the payroll tax is fully incident on the employee. But what if the employer decides to pay \$10,000 of that as health insurance? In that case, total taxes paid comes to \$11,240, and total compensation after tax comes to \$38,760.¹⁰

The end result is clear: the employee and employer pay less taxes with this exclusion, and the employee walks away with higher compensation when health insurance is included as part of the compensation package. A somewhat dated, though still relevant, analysis also suggests that the federal and state governments lose about 37 cents of revenue for each dollar paid as health insurance instead of wages.¹¹

⁸ Thomas C. Buchmueller and Alan C. Monheit, “Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform,” *Inquiry* 46, no. 2 (2009): 187–202.

⁹ “Internal Revenue Code of 1954,” Pub. L. No. 83–591, § 106 (1954).

¹⁰ This analysis simplifies a lot of the tax code and ignores standard deductions and the possibility of bracket changes with/without employer-sponsored health insurance.

¹¹ Austin Frakt, “Understanding the Employer Based Insurance Tax Subsidy,” *The Incidental Economist*, February 3, 2010, <http://theincidentaleconomist.com/wordpress/understanding-the-employer-tax-subsidy/>.

III. The Invisible Costs of ESI

At this point, it should be abundantly clear that the ESI system is expensive on the front-end – at over \$300 billion per year in lost government revenue. But the costs of this system are more than just lost revenue. The costs of ESI cut into a worker’s paycheck and make coverage more expensive (or unavailable) for middle and lower-income people.

Here’s how this all plays out.

For starters, when workers receive compensation, as in our previous example, some share of it is paid as health insurance benefits while another share is paid as cash wages. That is to say, ESI isn’t simply a gift from employers. More compensation paid as ESI means less is paid as cash wages. This isn’t only an economic theory either – indeed, the literature supports the idea that higher premiums offset wages and vice-versa.¹² This creates a situation where workers have little choice in whether they buy-up insurance coverage from work. Choosing not to means leaving money on the table and not having the same exclusion in the individual market. But reduced wages, and less control over health insurance decisions are just one part of the hidden costs of ESI coverage.

ESI coverage also makes insurance more expensive for two reasons. Consider an employer deciding how to split up compensation – under the ESI tax exclusion, devoting a larger share to ESI means fewer taxes paid for both employer and employee. So one reason that the ESI exclusion makes insurance more expensive is simply that it increases the demand for relatively more expensive coverage. Not only does it incentivize employers to offer coverage, but it incentivizes employers to buy *more expensive* coverage.

This leads to the second reason. For many years now, economists have recognized that if you give people too much health insurance, they’ll buy more things and more expensive things with it. Think about how you decide whether to make an appointment for an annual physical – if you have a copay, you might think twice about it. Or when you’re buying prescription drugs – if you have to spend some money upfront, you might ask for the generic version of the drug when filling your prescription. Thus, when patients have relatively generous coverage that protects them from the underlying cost of health care, even for low-value services, they’re going to be less sensitive about the costs of care. This creates more demand for health care services, which in turn raises the cost.

This means that doctors, pharmaceutical companies, and hospitals know that when you’re paying for health care, you’re not seeing anything remotely close to the full cost. And that means that an extra MRI here, another appointment there, or one or two extra blood tests that might not be necessary are now profitable.

Of course, the case for subsidizing health insurance, is strong. Otherwise, many people might avoid buying health insurance at its full cost because they don’t need it today. They might wait until they’re sick to purchase it, or simply not purchase it at all. This would defeat the very purpose of health

¹² Katherine Baicker and Amitabh Chandra, “The Labor Market Effects of Rising Health Insurance Premiums,” *Journal of Labor Economics* 24, no. 3 (2006): 609–34.

insurance. Nevertheless, this tax exclusion isn't a good way to subsidize health insurance for those who can't afford it. The main reason is that the exclusion is extremely regressive. Intuitively, this makes sense. Those who receive the biggest benefit from it (paying less in taxes than they otherwise would) are those in the highest tax brackets. Not surprisingly, those are typically people with relatively high incomes. It turns out that roughly five-sixths of these benefits flow to people in the upper half of the income distribution. One particularly damning analysis noted that "[t]he share of the benefits [going] to the top income decile are more than thirty times as large as those to the bottom income decile."¹³

This system that has helped ensure that most Americans stay away from buying portable, individual coverage, and instead cling to coverage through their jobs. Prior to the ACA's coverage expansions (though this is still true to a large extent), the non-group private market was primarily there for people who fell through the cracks. Partly, this was certainly because the tax exclusion made it unwise for most people to seek coverage elsewhere. But the weakness of the individual market is also a case-study in well-intentioned, but poorly designed state regulations.

IV. New York: Good Intentions Go Awry

It's often noted that health care is local. This makes sense. You don't want to travel too far to see your doctor, you'll most likely want to use the hospital relatively nearby, and when you buy health insurance, the plan is priced based on local conditions. So it also makes intuitive sense that states and localities tend to play a major role in regulating health care. After all, decision-makers in Washington may not fully appreciate the differences in health care needs between large cities like Chicago, and smaller towns in the south.

But while keeping regulation somewhat local might make sense, that doesn't mean that all local regulation makes sense. In fact, a good chunk of what's wrong in our health insurance system could be linked to poorly designed state regulations.

Take New York for example. The Empire State's history with trying to regulate its individual market offers a profound case-study in what not to do.

In 1993, New York State enacted a series of health insurance market reforms. These reforms were certainly well-intentioned. They came on the heels of a series of revelations that the dominant health insurer in the state, Empire Blue Cross Blue Shield (which was losing money), had been lying to regulators in order to receive approval for large premium increases. This was particularly jarring as Empire Blue Cross Blue Shield was the only remaining insurer in New York's commercial individual market at that time.

That being said, while much of the insurer's woes were its own fault, some of them came out of regulatory failure pre-1993. As a quasi-public insurer of last-resort in New York, Empire Blue Cross Blue Shield was required to sell insurance policies with so-called "community rating." Essentially,

¹³ Ibid at 4, p.15.

rates couldn't vary based on health status, age, gender, or any other characteristic. (In exchange, Empire was exempt from state and local taxes, and received state-mandated discounts for hospital services.) In hopes of promoting competition and reducing costs (which were beginning to grow in the 80s partly due to Empire's aging insurance design, the growing AIDS epidemic, and other factors) New York permitted other insurers to enter the market while still keeping community rating requirements imposed on Empire. These new competitors could vary rates. As a result, lower-cost customers began leaving Empire while higher-cost customers remained.¹⁴ This drained money out of the insurer's coffers, as the remaining customers were significantly sicker. Economists refer to this phenomenon as "adverse selection."

So, in 1993 regulators decided that in order to level this playing field, all insurers selling policies in the individual market should be required to implement community rating. In addition, insurers had to sell policies to all-comers, meaning that there was no penalty for waiting to enroll when you became sick. Of course, this was beneficial to some. The sickest and poorest patients might have had an easier time finding an insurance plan with these regulations in place. But those who don't have as many pressing health care needs were now being asked to pay the same rates as the sickest. Economics doesn't lie, and the results were easy to predict.

By 2013, premiums had skyrocketed in New York. Across three of the largest plans serving New York State, monthly premiums were well over \$800. This coincided with a massive decline in the number of people in New York's individual market, dropping to only around 20,000.¹⁵

The failure of New York's individual market also came with a human cost. When insurers can't charge the sick more than the healthy, but the healthy have little reason to enroll, insurers will – as one might expect – try to find ways to cut costs in other ways. The story of Ian Pearl¹⁶ – a patient with muscular dystrophy – demonstrates how this plays out. Mr. Pearl, who had spent 37 years in a wheelchair and required round-the-clock care relied on nursing home benefits provided by a New York-based insurance company. In December 2008, rather than continue to offer the increasingly expensive plan, the insurer simply canceled it claiming that the plan had become too expensive to sell. The replacement plan the company offered did not have comparable benefits which made it less expensive and easier to market. In a more sane world, community rating would come with carrots and sticks for the healthy to enroll – ensuring that plans like these were still sustainable.

Of course, regulators never intended to decimate the state's individual market. The goal was always to fix it, and ensure that those worst off would have affordable access to health insurance. But unintended consequences of regulations are the rule, rather than the exception. New York's

¹⁴ James C. Robinson, "The Curious Conversion Of Empire Blue Cross," *Health Affairs* 22, no. 4 (July 1, 2003): 100–118, doi:10.1377/hlthaff.22.4.100.

¹⁵ Peter Newell and Nikhita Thaper, "Affordable Care Act Brings New Life—and Covered Lives—to New York's Individual Market" (United Hospital Fund, May 2016), <https://philanthropynewyork.org/sites/default/files/resources/IndMarket-layout-20160525.pdf>.

¹⁶ "Insurer Ends Health Program rather than Pay out Big," *The Washington Times*, accessed April 19, 2017, <http://www.washingtontimes.com/news/2009/oct/14/ny-insurance-company-tries-to-rid-itself-of-high-c/>.

experience with trying to “fix” their individual market is an important lesson in caution when it comes to regulations in health care.

V. A Path Forward: Fix the Tax Exclusion

Despite these and other problems, for better or worse, American health care will likely continue to rely on third-party payment – health insurance – for most services. And much of this will remain regulated at the local level. But this makes ensuring that insurance markets function properly an increasingly important goal.

“Properly functioning” in this sense, is actually simple to define. We need a health insurance market that is accountable to patients, doesn’t push up health care prices unnecessarily, and one that provides a product that follows a person regardless of their employment situation. Since we’ve established that, contrary to what some might believe, the tax exclusion for employer-sponsored health insurance does the opposite, the first step is to neuter that exclusion.

This was partly done under the Affordable Care Act (ACA or Obamacare) through the so-called Cadillac Tax. This tax is a 40 percent excise tax, originally slated to begin in 2018, on the value of health insurance benefits above a certain threshold that grows each year. The basic idea behind it was to undo the tax exclusion without actually eliminating the tax exclusion. While taking action on the exclusion was a good idea, the Cadillac Tax was an unnecessary cudgel. Specifically, the 40 percent excise tax is highly regressive. Economists generally accept that these kinds of taxes will be passed on to employees through reduced benefits or higher premium contributions. In a world without a tax exclusion, employees would simply pay their marginal tax rate on the value of these health benefits. Lower-income workers would pay less, while higher-income workers would pay more. In the world of the Cadillac Tax, all workers pay the same rate.

Thanks to pressure from business groups, pharmaceutical companies, unions and other special interests, the tax was delayed through 2020 and was slightly modified. While the regressivity remains, it has been somewhat reduced. The tax is now deductible from businesses’ taxable income. In simple terms, this means that the tax is considered a cost of doing business that reduces companies’ total taxes owed. For a company at the 35 percent tax bracket, this puts the “effective” tax rate for taxable benefits at 26 percent.¹⁷ To reiterate, because these costs get passed on to the employee, an employee at a tax rate lower than 26 percent will effectively be paying a higher rate on these benefits.

The solution here is incredibly simple – either eliminate, or limit the employer-sponsored health insurance tax exclusion.

Eliminating the exclusion couldn’t be instantaneous. Because of the large number of companies and employees that rely on this system, some transition period would be necessary. One approach might initially limit the exclusion to some threshold, and over time reduce that threshold until it hits zero.

¹⁷ Scott Greenberg, “The Cadillac Tax Will Now Be Deductible. Here’s What That Means.,” *Tax Foundation*, January 14, 2016, <https://taxfoundation.org/cadillac-tax-will-now-be-deductible-here-s-what-means/>.

That would give companies time to modify their plans and figure out how to adjust to a world without the exclusion.

Alternatively, a reform plan might seek to still preserve the ESI exclusion but cap it at a reasonable level. The details of how to do this are complicated, but one might set the cap at the 75th percentile of premiums, for instance, ensuring that three-fourths of plans are unaffected. Other approaches to minimize the disruption are also available – for instance, excluding health savings accounts (HSA) contributions from being covered by this limit.

Whatever reform looks like, some would pay higher taxes as a result. Employees with companies who don't modify their plans will be subject to higher levels of income tax. But it's likely that employers will respond in force. A survey from consultancy Deloitte suggests that around one-third of employers have already begun reducing generosity of health benefits in response to the Cadillac Tax.¹⁸ A similar response should be expected in response to eliminating the tax exclusion. And an immediate benefit for workers will likely be a bump in wages. This goes back to the total compensation concept introduced earlier. When one part of total compensation declines (in this case, health benefits) another will rise to fill its place.

Of course, the biggest benefit of eliminating the exclusion won't simply be higher wages. The biggest benefit will be to begin the move away from a health insurance system tied to employers. Instead, a more flexible and patient-centered system will take its place. Ultimately, the goal will be for employees to purchase insurance independently of their employers. While many employers might still want to offer health insurance or assistance with purchasing health insurance, the incentives to do so will be greatly reduced.

With a health insurance system that caters to individual patients, benefits would be right-sized to what patients actually want. In turn, providers of health care will have to think more carefully about how to price their services and what services to offer.

One potential stick in the mud is states and localities. While the federal government can help undo its own damaging legislation and regulation, states are still responsible for theirs. Thinking back to the New York case study, it isn't clear exactly what the world without the employer tax exclusion would have looked like. If the lack of a tax exclusion had made the individual market a much larger source of insurance in 1993, legislators may never have passed their package of "reforms" to begin with. On the other hand, the lack of the tax exclusion wouldn't have been able to save New York's individual market from these reforms either.

This is where states and localities become particularly important. No changes to insurance market regulation at the federal level can fix what states have already harmed. This is why, if the goal is to have an insurance market accountable to patients, states must also get onboard with pairing back

¹⁸ "Are Employers Prepared for the 'Cadillac' Tax?" (Deloitte, 2015), <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-cadillac-tax.pdf>.

well-intentioned but poorly implemented insurance market regulations. New York, for instance, might consider allowing some variation in how much insurers can charge the young versus the old.

Nonetheless, federal efforts to eliminate or restrict the scope of the employer-sponsored tax exclusion can send the right signal and begin the gradual shift to a more portable, patient-centered health insurance system.