ISSUE BRIEF

ECONOMIC POLICY INSTITUTE | ISSUE BRIEF #267 DECEMBER 11, 2009

THE HOUSE HEALTH CARE BILL IS RIGHT ON THE MONEY

Taxing High Incomes Is Better Than Taxing High Premiums

BY JOSH BIVENS AND ELISE GOULD

On November 7, the House of Representatives passed HR 3692, a bill that provides for major reform of American health care. On November 18, the Senate introduced similar (though not identical) legislation. If the Senate bill passes, the two versions of health reform will have to be reconciled in conference committee. One key difference between these two bills is how each proposes to raise revenue to pay for reform.

The House bill would enact a surtax on very high incomes. Specifically, incomes over $1,000,000 (for joint tax filers; $500,000 for single filers) would be assessed a surtax of 5.4% to finance reform. The Senate bill would enact a 40% excise tax on the cost of employer-sponsored health insurance plans that exceed $8,500 for individual coverage or $23,000 for family coverage.

If the Senate passes a health reform bill with the excise tax, then the House and Senate will be forced to reconcile these two different financing mechanisms in conference committee. This Issue Brief argues that the House surtax raises more money, and it does so just as reliably but more progressively than the Senate excise tax. In addition, it details myriad potential problems with the excise tax, specifically:

- The excise tax will hit many workers with ordinary health plans, not exclusively high-value plans.
- The excise tax shifts health costs and risks onto workers and their families, especially hitting hard those with high medical needs.
- Consumers may respond to their increase in out-of-pocket burden by cutting back on medically indicated as well as cost-effective medical care.
- Even if workers receive cash wages in exchange for the cut in their benefits, their total compensation will still go down, and much of their wages may be eaten up by increased health costs.

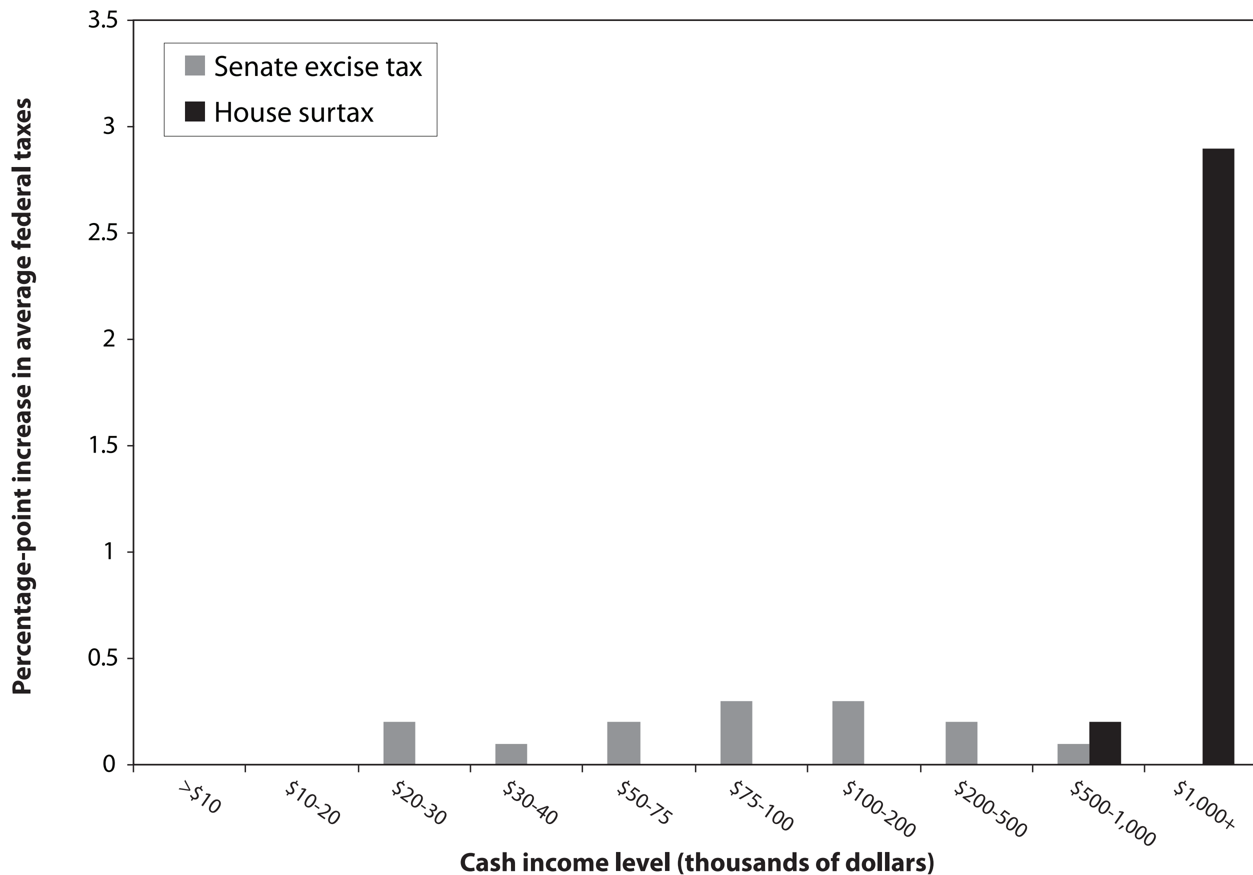
- Any cost containment from the excise tax is driven by reduced medical care, not reduced prices.
- The existing academic literature as well as indirect evidence provided by overall income tax changes in recent decades indicate that any cost containment from the excise tax will be completely swamped by other determinants of health care costs.

Raising revenue: House surtax versus Senate excise tax

The Congressional Budget Office (CBO) has estimated that the House surtax will raise $460 billion over the next decade while the Senate excise tax will raise $150 billion. Given the importance attached to making fundamental health reform deficit-neutral over the next decade, this not a trivial difference. The more money that is raised through these respective instruments, the less money that has to be raised through other politically contentious means in the future.

Besides raising more money, the House surtax raises it more progressively. The bottom 99% of households will pay nothing in a given year under the House surtax. Only the top 1% of households will pay the surtax. Proponents of the Senate excise tax often argue that it, too, is a progressive revenue-raiser by supposing that there is a strong link between high incomes and high-cost health plans. However, this correlation is less consistent than is often thought. Research by Gould and Minicozzi (2009) using data on health plan coverage by private establishments shows that the size and/or age

FIGURE A



SOURCE: Tax Policy Center and the Joint Committee on Taxation.

of an establishment's workforce is a more important determinant of having high-cost health plans than the share of the establishment's workforce that earns an above-average salary.

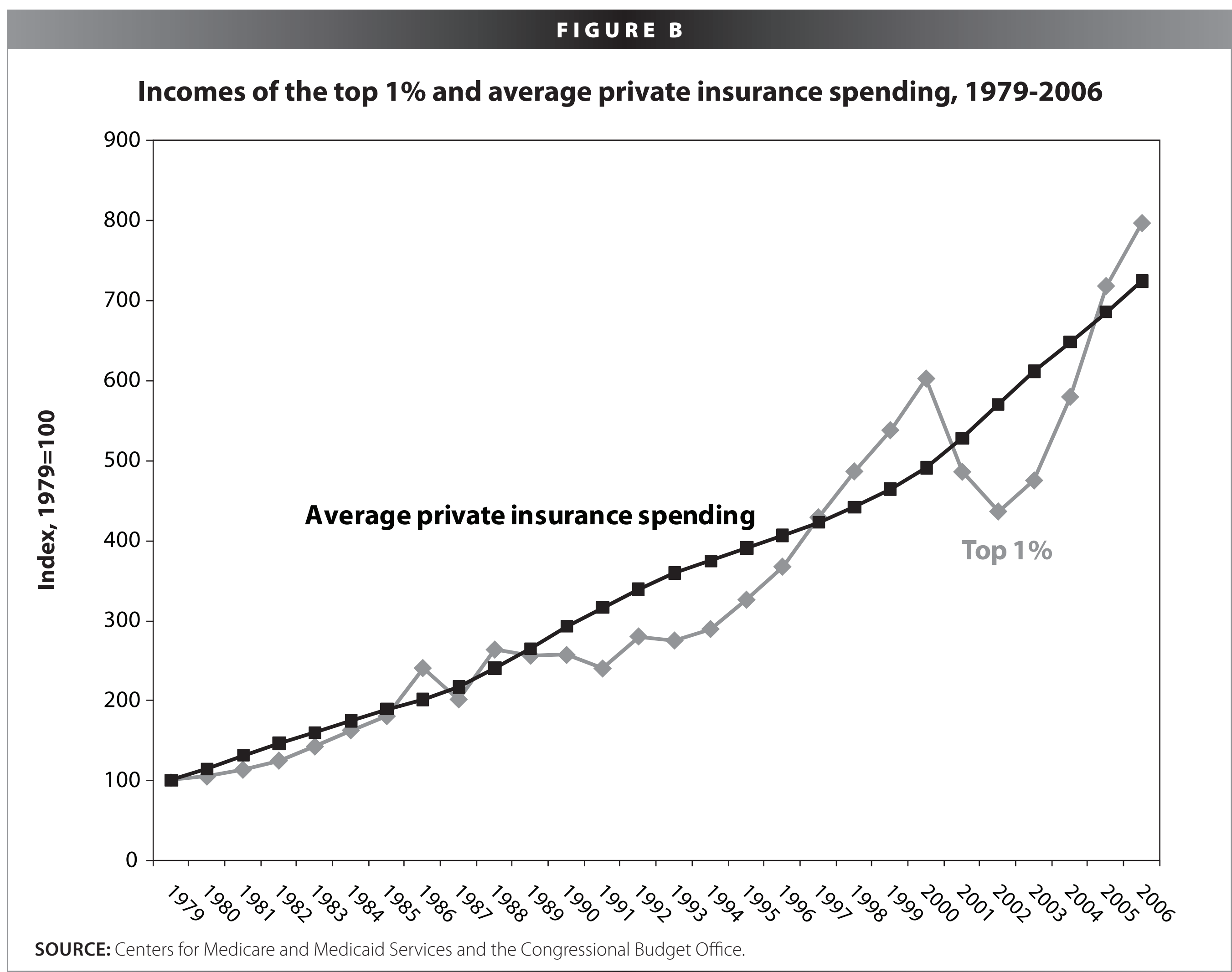
Figure A compares the change in average federal taxes by cash-income level for the excise and surtax respectively. The surtax is clearly more progressive.

It should be noted that the current Senate bill actually takes a step closer to the House financing mechanisms than to the bill originally passed out of the Senate Finance Committee. The new Senate bill raises the threshold for family plans affected by the excise tax and provides higher thresholds for retirees over 55 and for workers in certain high-risk professions. In short, the new excise tax will affect fewer households. Additionally, the new Senate bill contains an increase in the Medicare hospital insurance tax on wages exceeding $200,000. This new tax raises more than $50 billion over the 10-year budget window and is quite progressive.

Which revenues can keep pace with health care cost growth?

Finally, proponents of the excise tax often cite the growth in overall health costs to argue that a good revenue source for funding reform in the long-term needs to grow as fast as these costs. While a funding source that grows with health care costs is a desirable goal, it should be noted that for the last three decades one of the only things in the American economy that actually *has* grown as fast as overall health costs is the incomes of the richest 1% of households (see **Figure B**). While

FIGURE B



SOURCE: Centers for Medicare and Medicaid Services and the Congressional Budget Office.

it is theoretically possible that this could reverse in the future, this would be a clear break from the pattern of 35 years (and a welcome one at that). It seems reasonable to imagine that the top 1% of incomes will be a perfectly good anchor as a source of funding health care reform in the coming decades.

Policy benefits of Senate excise tax often exaggerated

Proponents of the Senate excise tax claim that it is not only a revenue-raiser for health care, but that it also could be a powerful tool in restraining the growth of American health care costs.

The theory behind this claim runs as follows. The excise tax penalizes high-cost health plans. If one assumes that high-cost health plans are high-value plans—that is, plans that provide comprehensive coverage of health care costs and expose beneficiaries to very low cost-sharing (co-pays, co-insurance, and deductibles), then these plans could lead beneficiaries to consume more health care services than they would if they had to face more of the marginal cost of each health intervention.

Facing a higher share of the marginal cost of health care (sometimes short-handed as "having skin in the game") will, the theory holds, provide incentives for consumers to spend less on health care, freeing up money to spend on non-health care goods and services.

These claims should be considered with some skepticism for several reasons:

- **The excise tax will hit many workers with ordinary health plans, not exclusively high-value plans.**

  The assumption that high-*cost* plans are high-*value* plans is flawed. Many health plans are expensive because the population covered is older or sicker than average, but they still do not provide more comprehensive coverage. Moreover, this is a much larger problem than is often recognized. Gould and Minicozzi (2009) have shown that some of the most powerful predictors of a plan's high cost are the size of the firm and the age of its workers. This is surely not a coincidence—small firms and firms with older workforces tend to have less bargaining power with insurance companies and this leads to higher prices for insurance coverage that may be no more comprehensive than lower-priced coverage for larger or younger firms. It should be noted that the Senate bill recognizes this reality and specifically exempts some health plans (those covering high-risk professions, for example) from the excise tax or raises the threshold of the tax explicitly on the grounds that high-cost is not synonymous with high-value.

  Furthermore, Gabel et al. (2010) find that only 3.7% of the variation in premiums for family plans is determined by a plan's actuarial value, that is, the share of average medical expenditures paid for by insurance (instead of by out-of-pocket spending). It is also worth noting that the Joint Committee on Taxation's (JCT) scoring of the excise tax indicates that plans with fewer enrollees are more likely to be affected by the excise tax. Given that previous research has shown that smaller firms pay premiums 18% higher than large firms pay *for equivalent health coverage*, it seems clear that this excise tax will be affecting many workers who have only high-cost—not high-value—health coverage (see Gabel et al. (2006)).

- **The excise tax shifts health costs and risks onto workers and their families, especially hitting hard those with high medical needs.**

  Nearly two-thirds of employers plan to cut health benefits to avoid the excise tax (Mercer 2009). Notably, a full 7% would eliminate their health plan altogether. For those choosing to just reduce benefits, the vast majority expect to increase deductibles and copayments. Forcing people into less-comprehensive plans means that they will be exposed to higher out-of-pocket costs and greater health-related financial shocks. People value insulation from these shocks (this is why insurance exists, obviously), so forcing them into less-insulating plans has a cost. While pressuring people into less comprehensive plans is one of the goals of the policy, it is clearly not an unambiguous policy victory.

Shifting costs onto workers and their families has detrimental affects on their ability to maintain and secure affordable health care. Such costs have already risen in recent years with increasing out-of-pocket burdens and increasing difficulty in paying medical bills (Gabel et al. 2009; Tu and Cohen 2009). Furthermore, Himmelstein et al. (2009) find a striking growth in bankruptcies associated with medical costs, even for those households covered by health insurance. Pushing insurance plans to be less comprehensive will just make these problems worse.

- **Consumers may respond to their increase in out-of-pocket burden by cutting back on medically indicated as well as cost-effective medical care.**

  If the excise tax pressures people to purchase health plans with increased cost-sharing (e.g., higher copayments), consumers may very well respond to this effective price increase by haphazardly cutting back on medical spending. However, many of the interventions that are avoided may turn out to be health-improving and/or cost-effective. This problem is especially true for vulnerable populations. Research has demonstrated that low-income and chronically ill populations are generally harmed by higher cost-sharing and may actually incur *higher* overall costs in response to the introduction of this cost-sharing, as they cut back too much on cost-effective managing of chronic conditions.

  Research has found that the optimal cost-sharing rate for many chronic conditions and large classes of prescription drugs is very low or even zero. This same research shows that increased cost sharing in certain areas (e.g., prescription drugs or primary care) can lead to higher overall costs due to increased utilization in other areas (e.g., hospitalization). A selection of this academic research is highlighted in the below box, *Academic Research on Cost Sharing*.

ACADEMIC RESEARCH ON COST SHARING

- Gruber (2006) and Hsu et al. (2006) demonstrate that higher cost-sharing is detrimental to the health of the chronically ill.
- Mahoney (2005) finds that lowered cost-sharing for diabetes patients reduced health costs per plan.
- Rosen et al. (2005) find that reduced cost-sharing for ACE inhibitors for Medicare beneficiaries with diabetes both extend life-expectancy and reduce overall Medicare program costs.
- Goldman et al. (2007) find that higher cost-sharing for pharmaceuticals is associated with an increased use of medical services, particularly for patients with greater need (e.g., heart disease, diabetes, or schizophrenia).
- Chernew et al. (2008) demonstrate that cost-sharing with lower costs for those for which the intervention would be most cost-effective (generally the chronically ill) leads to higher compliance.
- Muszbek et al. (2008) find that increased compliance with drugs for hypertension, diabetes, and a series of other ailments will lead to higher drug costs but lower non-drug costs, leading to overall cost savings.
- Chandra, Gruber, and McKnight (2009) find that there are substantial "offset" effects to broad increases in cost-sharing rates for physician visits and prescription drugs; spending on these categories fell with higher cost-sharing but hospitalization costs rose substantially.

Overall, the evidence clearly shows that an optimal cost-sharing design should take all of the considerations raised by different patient populations, therapies, and conditions into account. In short, efficient cost-sharing designs cannot be one-size-fits-all.

However, the design of the excise tax addresses *none* of these considerations, suggesting that it is far too blunt an instrument to make efficient cuts in health care utilization. The proper place to cut out inefficient health care is on the supply-side—through delivery system reform and comparative effectiveness review (see Cutler (2009) on the promise of delivery-system reform for cost-savings)—not on the demand-side by squeezing patients (often those unlucky enough to work for firms with fewer or older employees) with higher out-of-pocket costs.

- **Even if workers receive cash wages in exchange for the cut in their benefits, their total compensation will still go down and much of their wages may be eaten up by increased health costs.**

Proponents of the excise tax often note that if it encourages workers to take less compensation in the form of health insurance premiums, then this could raise other forms of compensation, especially cash wages. And given that the excise tax is forecast to lead to non-trivial cuts in premiums, this means that cash wages may indeed rise. However, the lion's share (roughly two-thirds in 2013) of these wage increases will just be used by workers to pay the higher out-of-pocket health costs they will incur due to the imposition of the excise tax *even if the excise tax proponents are right about its impact on overall health spending* (see box on page 7, *The Excise Tax: A Horserace between Higher Out-of-Pocket Costs and Higher Wages*, for a discussion on how this works). This share of potential wage-gains that will have to go to meet higher out-of-pocket costs is an average. Given the very large variability in health spending (i.e., many families spend next to nothing on health costs in a given year while some spend enormous amounts), it should be noted that in a given year many workers will see increases in out-of-pocket costs that far exceed the potential addition to cash wages that accompanies the imposition of the excise tax. Again, this is a consequence of the risk-shift that will be spurred by the excise tax.

Of course, if the excise tax does not reduce health spending by as much as its proponents forecast, then an even higher share of the increased cash wages will go to paying for out-of-pocket costs that were once covered through insurance.

Furthermore, the potential for cash wages to rise in response to the excise tax has been characterized lately in many venues as providing a "raise" for American workers. This is incorrect: the excise tax is *reducing* overall compensation, period. The fact that cash wages rise just means that other forms of compensation are falling. And because some compensation that was previously being subsidized through tax policy (employer-paid insurance premiums) is now being taxed, the result is a cut, not a raise, to total compensation for American workers. There is no ambiguity about this.

- **Any cost containment from the excise tax is driven by reduced medical care, not reduced prices.**

The mechanism for cost-containment should be well-understood: the excise tax will not lower premiums or the price of health care for anybody not directly affected by it. Instead, if it works to contain costs, it will do so by encouraging the people bearing its incidence to *buy less health care*. If one believes that the most pressing way that American health care lags its industrial peers is high prices, not high utilization, then the excise tax does little to remedy this (see Andersen et al. (2003)).

Any reduction in national health spending caused by the excise tax results from households consuming less health care because it has been made more expensive to them—not because health care is made cheaper or delivered more efficiently.

THE EXCISE TAX: A HORSERACE BETWEEN HIGHER OUT-OF-POCKET COSTS AND HIGHER WAGES

If workers begin accepting less-comprehensive coverage in order to avoid the excise tax, this implies that their wages may rise if employers shift compensation away from high-cost health plan premiums and toward cash wages. However, less-comprehensive health coverage also means that a higher share of spending on medical care now has to come from workers' own pockets. This increase in out-of-pocket costs will, in fact, claim the lion's share (two-thirds in the first year of the excise tax) of the potential wage gains resulting from the excise tax.

Take an example of a worker with an insurance plan fully paid for by her employer that costs $24,000 and covers 80% of her family's medical costs in a given year; the worker pays the 20% remaining out-of-pocket in the form of co-pays or the like. To avoid the excise tax, the worker accepts a plan that costs $23,000 but covers only 70% of their medical costs. This worker may get an extra $1,000 in wages as her employer is now spending less on health insurance premiums. However, say that her family spends $6,000 in medical costs over the year (given that *per capita* health spending in the United States is close to $6,000, this is actually far less than average health spending for a family). In this case, she is now responsible for an extra 10% of their overall medical bills out-of-pocket. Because of their new, less-comprehensive coverage, higher co-pays, deductibles, and co-insurance will eat up $600 of her $1,000 raise.

Of course, it gets slightly more complicated. Proponents of the excise tax say that as consumers face higher out-of-pocket costs, they will consume *less* health care overall. So, say that our worker above cuts her spending from $6,000 to $5,900 due to the cost shift spurred by the tax (this is actually a pretty generous assumption to the proponents of the excise tax). Even after cutting back on her family's medical care utilization, her out-of-pocket medical costs will still eat up $570 of her $1,000 cash-wage raise.

The rough numbers in this example are not that unrealistic. Using data from the 2006 Medical Expenditures Panel Survey (MEPS), we undertake a similar calculation for the entire population affected by the excise tax and find that actually *two-thirds* of the rise in cash wages predicted by proponents of the excise tax would be used to pay higher out-of-pocket costs, *even if the excise tax led to the reductions in overall health spending that its proponents claim*. If there was no decrease in health spending spurred by the excise tax, out-of-pocket costs would take up close to 90% of the potential wage increase.

- **The existing academic literature as well as indirect evidence provided by overall income tax changes in recent decades indicates that any cost containment from the excise tax will be completely swamped by other determinants of health care costs.**

Even if all goes as its proponents claim, the proposed excise tax simply does not threaten to make a large dent in the upward march of American health care costs. For one thing, the sickest 20% of the population account for 80% of total health spending in a given year. Clearly, nobody thinks there should be significantly greater cost-sharing on the truly big-ticket items of health care—transplants, major life-saving surgeries, or the management of chronic diseases like diabetes. But if cost-sharing is not enforced on these big-ticket items, it has limited reach to affect the really big drivers of health care costs.

This can be inferred by looking at past changes to taxes that have affected the incentives to purchase high-cost insurance plans. For example, the increase in marginal tax rates in 1990 and 1993 should have, all else equal, significantly increased workers' desire to take more compensation in the form of tax-preferred premium payments for employer-sponsored health plans This choice in turn should have led them to facing less out-of-pocket exposure to health costs. By insulating themselves from the marginal cost of health care, this should have led to more health utilization and an increase in national health spending.

In 2001, by contrast, marginal tax rates were significantly reduced. This should have had the opposite effect: people should have chosen to take less compensation in the form of employer-sponsored premiums, faced higher exposure to out-of-pocket costs, and reduced national health spending accordingly. In a seminal paper examining the responsiveness of firms' decisions about employer insurance offering and spending to changes in its tax-treatment, Gruber and Lettau (2004) forecast that the 2001 tax changes should have led to a 3.5% reduction in spending by employers on health care, an effect roughly as large as what the JCT forecasts for the Senate excise tax. In short, the tax changes of the 1990s and 2000s are fully comparable in scope to the proposed Senate excise tax.

A quick look at the macroeconomic evidence, however, shows just how limited an effect these tax changes had on overall national health spending. In 1990s, health spending actually decelerated markedly growing 5.9% annually compared with over 11% in the 1980s. Meanwhile, following the 2001 cuts in individual income tax rates, private spending increased at a 6.9% rate through 2008. In short, other forces swamped the effect of these tax changes on overall spending. Given this, it is hard to see the Senate excise tax as a true "game-changer" in bending the overall cost curve.

Conclusion

A clear-eyed look at the data and previous research on the effectiveness of tax changes in changing the trajectory of health spending argues that the policy merits of the excise tax as an instrument of cost-containment are being vastly oversold. There are many other cost-containment devices that could have comparable effects that are not being debated as fiercely. To name one, neither bill contains strong provisions to allow the Secretary of the Department of Health and Human Services to bargain with pharmaceutical companies over the prices paid by the Medicare Part D program (the portion of Medicare that provides prescription drug coverage).

The Centers for Medicare and Medicaid Services projects that Medicare will spend $83.4 billion on prescriptions drugs in 2013. Even existing federal health programs (like the Veteran's Administration) manage to bargain for drug prices that are less than half what is paid by Medicare Part D, hence the savings that could be realized through this bargaining mechanism looks at least comparable to the excise tax (see Families USA (2007) for drug prices in Medicare Part D and the VA). As such, it is curious how this tax occupies such an outsized place in the cost-savings debate.

The excise tax has the potential to create a financial hardship for many working families, particularly those who rely on comprehensive coverage to cover costs of their serious illnesses. The excise tax is a cut in benefits, a cut in total compensation, and a shift in risk onto workers. Such a policy should not be considered until high-quality, affordable coverage is available to all who stand to lose in the employer market.

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