Ask the Experts: Tax Subsidies and Health Insurance
Kaiser Family Foundation Broadcast Studio
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LARRY LEVITT: This is Larry Levitt from kaisernetwork.org. Welcome to Ask the Experts, a regular interactive web show that provides in depth discussion of current health policy issues, and allows you to interact directly with the nation's top policy experts.

Imagine a federal health program that spends a couple hundred billion dollars per year or more. Spending is automatic, not subject to annual appropriation by congress, and expenditures increase each year at about the rate of growth in healthcare costs. We're talking about Medicare? No. Medicaid? No. It's actually the amount of foregone federal tax revenues each year from the tax subsidy for employer sponsored health insurance. This subsidy has been with us since World War II, and it's one of the driving forces behind the fact that most working age Americans get insurance through an employer. Yet it has it share of critics. Some say the benefits go disproportionably to higher income families. Others argue it's unfair to provide subsidies for people who get insurance from and employer, but not to those who buy it on their own. And some suggest that it leads people to be over insured. In fact, there are now a growing number of proposals from republicans and democrats to change the tax preference, to cap it, to extend it to people who buy non-group insurance, or to transform it into a credit.

We're joined by four experts to help sort out how the tax system works and what it would mean to change it. Gary Claxton is a Vice President at the Kaiser Family Foundation, where he directs the Health Care Marketplace project. Jason Furman is a Senior Fellow at the Brookings Institution and Director of Brookings' Hamilton Project. Jack Meyer is a Principal with Health Management Associates and has written extensively on health insurance issues and tax proposals. And Katherine Baicker is a Professor of Health Economics at the Harvard School of Public Health, and until recently she served as a member of the President's council and economic advisors. She's joining us by phone from the Boston area.

You can reach our panel of experts at any time during the show by e-mailing your questions to ask@kaisernetwork.org. We'll try to get to as many of you as we can. And thanks to all you for joining us.

Gary, let's start with you. I think the tax preference for employer coverage, the current tax preference, is confusing to many people, maybe because it doesn't even show up on the tax forms that people will be filing shortly. Can you explain how it works, I mean, how does this tax subsidy get to people?

GARY CLAXTON: Basically, it's an exclusion from taxation for a certain amount of compensation you get from your employer. So if you think about it, if your employer gives you a dollar for health insurance, that's not subject to either income tax or payroll tax; but if your employer gave you that same dollar as wages, it would be subject to income tax and a payroll tax.

LARRY LEVITT: So essentially people are paying lower taxes—

GARY CLAXTON: Right.

LARRY LEVITT: —because these benefits are coming in tax free.

GARY CLAXTON: That's right.

LARRY LEVITT: Not getting tax-like wages.

And the payroll tax is the social security payroll tax, the Medicare payroll tax and the normal income tax.

GARY CLAXTON: Right, and so for social security it's a little over 15-percent when you consider the employer and the employee share. And then for income tax, it depends on your marginal tax rate, which could be zero, but it could also be as high as, I think, 33-percent.

JASON FURMAN, PH.D: Thirty-five percent.

GARY CLAXTON: Thirty-five percent.

LARRY LEVITT: And if this tax preference didn't exist, what would happen? I mean, people would just simply pay taxes on their health benefits, like wages?

GARY CLAXTON: It's harder to know exactly how the system would work. Now people want to get insurance through their employer, in part because employment-based insurance has certain efficiencies and so people like that, but also because they can pay for it with pre-tax dollars, so it's much cheaper to get it through work, and that's the reason why the employer-based system is so strong. If we taxed the amount that employers contributed for your health insurance, fewer people would probably want to get their insurance through work, so we might have less of it, and almost for sure people would by less health insurance because it would be more expensive for them because it will have paid taxes on the dollars they're using to pay for health care, health insurance.

LARRY LEVITT: And there are a number of proposals to change this. I mean, President Bush has a proposal that he announced in his State of the Union last year. Senator Clinton on the campaign has proposed a change to the tax preference. Senator McCain has proposed a change. Could you just quickly describe some of these proposals?

GARY CLAXTON: Yes, I'll try. Like I said, under current law, the amount that your employer contributes is just not counted towards your income. What the President has proposed is to do away with the current exclusion, but to give people a deduction if they purchase health insurance either through their employer or otherwise, and the deduction would be larger if you got family coverage versus single coverage.

Senator McCain is somewhat similar in the sense that he would do away with the current exception, but families would get a tax credit, as opposed to a deduction, if they purchase health insurance either through their employer or otherwise. And the amounts for the credit are 2,500 for single coverage and 5,000 for family coverage.

Senator Clinton would keep in place the current exemption, but would cap the amount of benefit that higher income families could get if they had fairly rich packages.

LARRY LEVITT: Okay, so the main difference between President Bush and Senator McCain's proposal, they would both essentially do away with the exemption, but Bush would provide a deduction, McCain would provide a credit.

GARY CLAXTON: Tax credit. Right.

LARRY LEVITT: Okay. And Jason, you've written quite a bit about how the current tax preference or exclusion is regressive, that the benefits go disproportionately to higher income families. Why is that the case? I mean, how does that actually work?

JASON FURMAN, PH.D: Right, well first of all, just to explain the mechanics of it: If you have a tax exclusion, that means your income goes down. Your taxes only go down by the tax rate. So if your income goes down by 10,000 dollars and you were in the 10-percent tax bracket, that means your taxes go down by 1,000 dollars. If you're in the 35-percent bracket, it means your taxes go down by 3,500 dollars. So higher income households can get three, four times the amount of their taxes written down, because of this tax benefit, than low income households do.

Now, in effect, that's like saying, "We're going to go out and subsidize your purchase of health insurance. If you're a low-income family, we'll give you 10-percent off, but if you're a high-income family, we'll give you 30, 40-percent off the cost of your health insurance." And I think what's important about that is it's not just a fairness issues, and no one designing a system from the ground up would design one where high income households got a bigger subsidy for health insurance, but it's also an efficiency issue because if you're trying to design a health system that has the smallest possible government subsidies leading to the maximum possible health insurance for Americans, you wouldn't need such a big subsidy for a high income family to get health insurance. They're going to get it with a lot smaller subsidy. They're going to go out and get it. On the other hand, a low-income family, this may not be nearly a big enough subsidy to encourage them to get their health insurance. So this upside down system, it's not just that it's unfair, it's that it's an inefficient way to encourage people to get health insurance.

LARRY LEVITT: And how could you transform it? I mean, how could you take the current system? What are some approaches for taking and making it more progressive or more efficient?

JASON FURMAN, PH.D: Well, Gary was just describing some of those, and so the first step would be that you do pay taxes on the health insurance your employers give you. If that's all you did, you'd get rid of the regressivity, you'd get rid of the unfairness, but you'd also get rid of health insurance for tens of millions of people.

So probably that's not the step that we should take. You then want to go to step two and give tax credits to families that are right side up, that are larger for families that have lower incomes that are more likely to respond to those tax credits and more likely to need the money; so something like Senator McCain is proposing, except with two amendments: One, that those tax credits are more generous for low-income households, rather than flat for everyone, and second of all, you'd want make sure if people are not going to get their health insurance through employers that the individual market is a place that's more functional for them to get health insurance. And we'll probably come back and talk more about that in this conversation.

LARRY LEVITT: Yes, we certainly will. And let me just ask you too, I mean, how important is refundability for if you provide a tax credit, a credit meaning that it comes right off the amount you owe in taxes? For low-income families is it important to make that refundable as well?

JASON FURMAN, PH.D: Yes, it's absolutely important to make that refundable. A large fraction of the uninsured don't have any tax liability. So you can give them as many tax deductions as you want and it’s not going to lower their taxes; it’s not going to give them a subsidy. So you have to make it like the earned income tax credit, refundable, so that if you don't have any tax liability, you actually get a check from the government.

LARRY LEVITT: Kate Baicker, let me bring you in from Boston. And you were on the council and economic advisors when President Bush proposed his last tax deductibility proposal, and if you could talk a little bit about what the aims of that approach were. I mean, what were you hoping to accomplish through that proposal?

KATHERINE BAICKER, PH.D: Thanks for having me. I think Jason hit on one of the inefficiencies generated by the way we currently subsidize private health insurance purchased through employers, and that’s that it’s a bigger benefit for higher income people than it is for lower income people, but there are a couple of other inefficiencies built in there as well. You only get this favorable tax treatment if you buy insurance from your employer, not for the most part if you buy insurance on your own. And as it turns out, higher income people are more likely to have jobs that come with health insurance. So that builds further regressivity into a way that we finance it now. It means that people who are out buying insurance on their own not only face the higher administrative costs that might be incurred in the individual insurance market, but also get no help through the tax code.

And then there's a third inefficiency that I think is a little less obvious but is probably equally important in terms of inhibiting us getting the most bang for the buck out of our healthcare spending, and that's that when you subsidize insurance in this way, you subsidize certain forms of insurance more than other forms of insurance, and you subsidize more expensive health insurance relative to more basic health insurance.

As was discussed in the beginning of this conversation, when you buy a dollar more of health insurance through an employer-provided plan, you're getting it, in essence, on sale, based on what your tax rate is; whereas, if you purchase a dollar worth of care not through an employer-provided plan, you're paying full price for that.

So that means if you have a choice about having routine, affordable care covered by your employer-provided health insurance plan versus not covered by it and paid out of pocket, you'd much rather have it through the policy because you pay it with pre-tax dollars as opposed to— you know, and again there are exceptions to this, but for the most part— paying for it with after-tax dollars if you go out and buy it on your own. So health insurance now routinely covers all

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sorts of things that normally we wouldn't think of as something you need insurance against. Low cost, routine expenses that people would be able to afford on their own, they're instead paying for through health insurance in the form of higher premiums, and that comes with administrative costs and funds going to an insurer that otherwise wouldn't need to if you just went and purchased that basic care by yourself. But the tax code pushes people into those kinds of plans, and that means that people pay more for health care and more for health insurance than they would otherwise.

So the goal of moving towards something like a standard deduction, as the President proposed, or a flat credit, as McCain is proposing, is to eliminate all of those biases, to make the tax code neutral about whether you get insurance from your employer or on your own, whether you get a more expensive policy or a more basic policy, whether you lower your premiums by having higher deductibles or a more restricted network, or any cost-saving mechanism that you want to implement, the tax code shouldn't be pushing us one way or the other.

And so all of these proposals that have a flat amount, whether it's a credit or a deduction— and those have very different distributional implications— in essence, takes the tax code out of that decision making process and hopefully moves us towards a system where people are getting higher marginal value for their health care dollars because the tax code isn't differentially subsidizing certain kinds of purchases.

LARRY LEVITT: And let me follow up on a couple of points you made. The first about the non-group market that eliminating, essentially leveling the playing field between employer coverage and non-group coverage. What about the point Jason made about needing to make changes in the non-group market in order to make that market accessible to people. Do you think that's an important element to go along with this?

KATHERINE BAICKER, PH.D: I do. I agree that that's very important, and there are a lot of reasons that the non-group market doesn't function nearly as well as it should. First of all, having more people in a big risk pool is always better than having a smaller risk pool, but then there are other problems as well, some of which stem from the tax code treatment that we've been talking about.

If you have a choice of getting insurance from your employer or on the non-group market, you'd much rather get it from your employer because of this favorable tax treatment, and that means that people who are in the non-group market buy in larger there because they don't have a better choice available to them and they're trying to get out as quickly as they can, and that means that there is a different kind of risk selection going on and an unavailability of long-run contracts that would help that market function better. People also ought to be able to keep their good risk rating, their insurance premiums that are calculated based on their healthy status, even if they get sick. Insurance premiums shouldn't go up because of changes in your health status, as long as you're continuously insured. And that's not the case right now. So if people move from the group market to the non-group market, or they want to change insurers in the non-group market, or they are retiring from a job and no longer eligible for employer insurance, they shouldn't have to pay more because of their health status, and there are insurance market reforms that would make that more possible.

LARRY LEVITT: Jack Meyer, let me bring you into this and follow up in this idea of the employer market versus the non-group market. I mean, how do you think about these proposals we're talking about, which would level the playing field would, in some sense, encourage some movement from employer coverage to non-group coverage. Is that a good thing?

JACK MEYER, PH.D: Well, I think it's a bad thing. I don't know why we would want to drive people or incentivize them from basically good comprehensive coverage that they get through the workplace to the wild gyrations and huge inequalities in the non-group market. We found variations in premiums of 10 to one, 12 to one. Older, sicker workers are often priced out of that market, if not turned down, flat out rejected from that market. The congressional budget office has evaluated President Bush's plan, which has been described, and found that by the year 2016 there would be 16 million more people in that non-group, or individual market, buying coverage on their own. Eleven million of those 16 million, according to CBO, would come from employer coverage. They would lose good employer coverage and be out there on their own. Now, if you're a healthy 25 year-old, that's fine. You'd get something good in the non-group market. If you're a 50 or 60 year-old worker with a chronic medical condition, you're in deep trouble.

I think the goal of this tax reform should be to stop subsidizing health care for people like Bill Gates and start subsidizing it for a waitress who works the night shift and the day shift, is ineligible for Medicaid; her boss, the restaurant owner, doesn't offer her any coverage; she's ineligible for Medicaid; she can't afford to go to the non-group market; she makes maybe six dollars an hour plus tips. And so, in my mind, putting a ceiling, and I would do it through the exclusion, the way you described earlier that's in a part of Senator McCain's proposal.

But unlike the McCain and Bush approaches, I would couple it with broader health reform that would create a group arrangement, perhaps at the state level, that these people who don't have access to affordable employer coverage could buy into with a sliding scale subsidy, and get some help and have a choice of plans, and be assured that they won't be rated up to 10 times the amount because they have a diabetes or asthma or cancer, or some other condition. And that's not a takeover of the system. You would build on the employer-based system. Government would leave that alone. If you have employer coverage and you like it, you could keep it. But the problem with some of these proposals is that they would incentivize people out of good coverage into this highly inequitable market. So I view putting a cap on the deduction, or the current exclusion, as a good way to raise some of the revenue, not all, that we would need for broader health reform.

LARRY LEVITT: And this kind of group arrangement you're talking about, that might be, for example, like, the connector authority that Massachusetts has put in place?

JACK MEYER, PH.D: Yes, it could be the connector, and there would need to be some sliding scale subsidies, as Massachusetts' plan has, for people who are ineligible even for their expanded mass health Medicaid program, but still have trouble, and they require people to get coverage. And if you're going to require people to get coverage, you're going to have to make sure that they have a place to go. Requiring somebody to have coverage and then sending them to the non-group market is a very dangerous prescription.

LARRY LEVITT: So you wouldn't, just to be clear, you would not offer, kind of level the playing field between employer coverage and non-group coverage in terms of tax preference?

JACK MEYER, PH.D: It wouldn't be where I'd start. There's a certain case to do that if you do it in the context of other reforms. The problem that I have with the Bush proposal is not that there isn't a case to be made for leveling the playing field, but nothing else comes with it. So it's a bit like sitting down in a restaurant and getting a small house salad, expecting and entrée and then dessert, and then the waiter brings you the check and says, "This is all there is. I hope you enjoyed your salad." This proposal from President Bush is estimated to cover five million uninsured people. That's better than nothing, and it would level the playing field. But there's still 42 million others, and that number is going up and up. So we need to couple this reform with others.

LARRY LEVITT: Well, I want to— and you brought up the idea of how many uninsured would be covered through a plan or would be estimated to be covered through a plan like President Bush has proposed— I want to move into some of the e-mail questions and start with trying to get some facts, or at least some estimates of facts on the table. And we got one question, which was: What do the experts expect would the be effect of eliminating the current tax treatment of group insurance for employees? Would employers be motivated to offer less generous coverage? Would employees reduce their coverage take-up rates?

And I want to broaden that a little bit and look at what you all think would be the effects of removing the exclusion and then potentially coupling that with a credit or a deduction in the non-group market. And Jason, let me start with you. I mean, how do we think about what these effects would be?

JASON FURMAN, PH.D: If it's just removing the exclusion, we have one example of that happening in practice, which is Quebec, eliminated the exclusion on supplementary employer insurance. They all get a basic package through the government, but you can get a supplement through your employer. They eliminated that, and a large number of employers dropped their supplementary insurance in the province of Quebec.

Now, the United States is obviously different than Canada. We don't have the basic insurance to fall back on, and most importantly, they didn't use that money to put it back into the health system to pay for something else. But that example by itself, and then simulation work that scholars like John Gruber and other have done, suggests that a lot of people would, a lot of employers would stop covering people, and most of those people would not be able to get another insurance plan if that's all you did. If you extrapolated Quebec to the United States you get 35 million people dropping coverage, about five million of them being able to get it in the individual market. That's a way rough ballpark, but it's a large number.

Then the next question is if you take that money you're saving, and unlike Quebec, you actually plow it back in the way that we've been talking, plow it back into the health system, then you can potentially increase coverage a lot. And estimate for proposals out there range from a low of about five million newly insured to John Gruber has designed and simulated a plan that would cover every single person. It includes a mandate and connector mechanism, but shows that you can just using this exclusion money, it's enough to cover everyone. So somewhere in the five to 47 million range, depending on how you design and who does the estimate.

LARRY LEVITT: And you mentioned earlier the idea that the current exclusion is in effect subsidizing higher income families who don't necessarily need it to buy insurance. I mean, if you remove the exclusion, do you feel confident that those higher income families would maintain coverage even without it?

JASON FURMAN, PH.D: I'd have a much smaller one. So rather than a 10-percent subsidy for people at the bottom and a 35-percent subsidy for people at the top, I might do something like the reverse of that, but I think I'd keep some subsidy all the way up the income spectrum.

LARRY LEVITT: And Gary, you've done some of this work with John Gruber at MIT. I mean, are these kind of the pieces, the kind of movements we would expect from this kind of plan?

GARY CLAXTON: Right, particularly if you got rid of the exclusion but then didn't do anything else, you would see some loss of employer coverage. Some people would lose coverage but because the non-group market is really not attractive, you know, I think fairly well-off people would still want to get coverage through their employer, but they would probably buy a lot less generous coverage because it wouldn't be tax preferred. But you would still keep that in place. Where you start to see large movement from the groups, the non-group market, is when you also put in a tax credit for non-group insurance.

Then you have situations where in firms where there are higher compensated workers and lower compensated workers, the higher compensated workers might want to just sort of take that money and go to the non-group market, and the employer would keep the money they're now spending on the lower paid workers and not give it to them, and those folks might not be able to purchase. So that's where you start to see, in John's model, a loss of coverage, is when those employers say, "Well, some of my workers will be just as well off in the non-group market, and the others probably won't fare as well."

LARRY LEVITT: And this is a combination of employers potentially dropping or lowering their contributions or coverage and employees making the decision to move as well, based on their own finances.

JASON FURMAN, PH.D: Right. Well, once enough employees move, then the employer doesn't offer any more as well, because insurers don't really want to take just the few employees left who want coverage there. So it starts to unravel in different ways.

LARRY LEVITT: And Kate, in looking at or in thinking about the plan that President Bush proposed, I mean, do you agree that this is the kind of movement that would happen?

KATHERINE BAICKER, PH.D: I think the direction is definitely correct in the sense that if you move from a system that differentially subsidizes the employer market relative to the non-group market towards a system that treats them equally, you're removing a big push towards the employer market. That has to make the non-group market relatively more attractive and the employer market relatively less attractive. What I think is much less clear is the magnitude of that effect, and we're seeing an existing trend, particularly among small and medium employers, away from offering health insurance. Leveling the playing field in this way would probably somewhat accelerate that trend.

What I'm not clear about is how big that acceleration would be, relative to the existing trend, and how we would balance that effect against the effect of giving help to people in the non-group market who are currently not getting any help.

Now, that said, I think you definitely want to couple a policy like this, that gave an equal tax treatment to the group and non-group market, with increased funds and flexibility for states, or a federal program to help deal with the transition problem of the chronically ill worker who’s hiding in an employer group pool and is getting subsidized, and then by more healthy workers who’s employer then stops offering health insurance. People go to the non-group market and get re-underwritten.

And that’s fine for people who are healthy, and a problem for people who are sick. That’s a real problem for sicker, older workers trying to move from the employer market to the non-group market. They would certainly need some transition assistance if you were moving from one way of financing health care to another way of financing health care. And I wouldn't want to minimize the real concern that we should have for that group of people, but I think the help that we would give that group of people is more like a transfer and less like insurance, that it’s very hard to insure somebody who’s already sick because the bad state of the world has already happened. It’s no longer insurance. It’s a subsidy or transfer help. And we’d want to structure it that way, rather than trying to design an insurance market around the problems of people who are newly purchasing insurance and already sick.

LARRY LEVITT: So when you talked about a transfer to this group of people, let’s say the older or chronically ill group of folks, I mean, could that be like a risk-adjusted creditor deduction? One of Senator McCain’s surrogates, Douglass Holtz-Eakin, former director of the CPO, has talked about potentially risk adjusting these tax credits by health status an age. Is that a viable approach?

KATHERINE BAICKER, PH.D: I think that that has a lot of promise. There are obviously a lot of details that make any plan much more complicated than we’d like to talk about now, but the idea of doing something like a risk adjusted voucher opens up a lot of possibilities that I think wouldn’t otherwise be on the table. So imagine that if you are diabetic you’re given a much bigger voucher with which to buy health insurance, and you can then take that voucher anywhere you want to any insurer. Maybe you go to an insurer who specializes in the disease management of diabetic care. You could end up with much more effective insurance because insurers would no longer be trying to repel sick workers, or sick enrollees, while attracting healthier enrollees.

So you’d lose that incentive for cream skimming because they’d be getting a bigger voucher. And individuals who were sicker would no longer have as hard a time being able to afford insurance, but you’d’ still have competition by insurers, and you would still have choices for people to make about what kind of insurance they wanted. So a program like that I think would help alleviate a lot of the problems you might otherwise see in the individual market.

LARRY LEVITT: Gary, you’ve studies the non-group market, worked on it quite a bit in your career. What kind of premiums do you see in the non-group market today. I mean, how do they vary by age, by health status?

GARY CLAXTON: Well, premiums, while they vary across insurers and by type of plan, I mean, for a common set of benefits they may vary by age by 500-percent, you know, five to one in terms of someone who’s 22 versus someone who’s 60, maybe even a little bit more for some insurers, a little bit less for others. Women pay more, and they would pay a lot more if maternity benefits were actually covered in the non-group market, but they’re generally not. Then in terms of health status, in a lot of states you have to show that you’re healthy enough to buy non-group insurance, or else they won't sell it to you.

In some cases they can charge you what’s called a substandard rate. Those can be as much as 50-percent more. At some point, insurers will not just keep charging you a higher rate because if you’re willing to pay a much, much higher rate they figure you’re even sicker than they can determine, and so they just don't want to. It sort of raises part of the problem with the risk adjustment that was just discussed. Risk adjustment can work out really well for insurers on average, but in the non-group market, people line up and come in one by one. So just having a slight, you know, even a voucher that’s worth twice as much isn't going to make you attractive if you’re a relatively sick diabetic. And they're not going to take the risk of 100,000 dollars of a potential payout to get a couple hundred dollars more in premium. So I think this is a really difficult concept if there’s not sort of some guarantee that you can get coverage.

Then, of course, there’s also substantial variation in the non-group market just based on the level of coverage. The deductibles tend to be much, much higher, and so the premiums you see are actually relatively low compared to group coverage, even though the administrative costs are high. It’s just because the coverage is a lot less. So when you look, the amount of health expenditures that are covered by non-group policies is much lower than the amount of health expenditures covered by group policies, or share I guess I should say.

LARRY LEVITT: Kate had mentioned the idea of potential enhancements to proposals like this, but guarding against making them too complicated, and we got a number of questions about sort of administrative issues in systems like this. One was how do we track these tax dollars. How would we know that the people who were given the money would actually spend it on health insurance? And there are a host of other administrative issues. I mean, these proposals have been around for quite a while. The IRS and others have said they'd be very difficult to administer or implement. Jack, can you give us a sense? I mean, what are some of those administrative or implementation challenges, let's say, of capping the exclusion, eliminating the exclusion, providing a credit for non-group coverage? I mean, what are some of the administrative issues you have to think about?

JACK MEYER, PH.D: Well, you would have to impute a value to the coverage. If you're going to have workers declare the employer contribution as taxable income, then you're going to want to know what is it that that employer is buying for you, and that would take some work to do. The credit— there'd be challenges of taking that credit and getting it to a health plan. We're facing those now in the health care tax credit for displaced workers, and we've worked out a lot of the problems of taking the employer share, which there is 65-percent, combining with the worker share and getting it to a health plan. But I think the important thing is to remember we're talking about the American healthcare system here. There are alternatives to turning workers loose, with a voucher or a tax credit, that still build on the system.

For example, a lot of people are surprised to learn that a homeless fellow on the street, who has severe mental, emotional disorders and would greatly benefit from psychotropic drugs that would treat bipolar disorder or schizophrenia, is ineligible in most cases for Medicaid because he or she has no dependent children. Someone with no income gets no help whatsoever. We were also told last year there wasn't enough money to reauthorize the children's health program and bump it up a little bit and enhance it. And we also have talked about connector type models that would require a sliding scale subsidy. You could put a tax on the current open-ended exclusion and put some of the money at least into bringing that person that's either homeless or making the minimum wage, who today get's nothing, brining them into an existing program that already has an administrative apparatus set up, whether it's the children's health program for the kids or Medicaid, and not everybody. I'm just talking about people that are dirt poor that get nothing. So I think it's feasible, and I think we have to view the revenue source here from placing this cap as a stream of money that could be used in a broader health reform package to help our neediest citizens, because the number of uninsured is going up every year, and I think it's going to go up more sharply.

LARRY LEVITT: And we've talked a lot about— we've been lumping these proposals together; there's obviously big differences among some of these proposals— and in particular a deduction, providing a standard deduction versus a credit. And Jason, you touched on this a little bit earlier. I mean, give us a sense of what are the magnitude of these differences, particularly in terms of the distributional consequences of these plans.

JASON FURMAN, PH.D: A 15,000 dollar deduction is basically worth whatever tax bracket you're in times 15,000 dollars. There's another small footnote to that in terms of payroll taxes. You'll get your payroll taxes reduced today, but then you get your social security benefits reduced in the future. So in effect, I'd rather not include that as part of the overall subsidy.

So the result is, with a 15,000 dollar deduction, if you're in the zero percent bracket, it's worth nothing, in effect; 15-percent bracket maybe 2,000 dollars; 35-percent bracket it'll be worth more than twice as much. Contrast to credit you can dial in whatever way you want. You can make it flat. You can make it more for some people. You can make it less for other people. And I think that's why the vast majority of the economics profession, analytic community would rather see a credit than a deduction. When the President's proposal came out, the Heritage Foundation said it would have been better as a tax credit. Republicans in congress said it would have been better as a tax credit. Greg Mankiew, former chairman of President Bush's council of economic advisors said that I think the deduction is something that people do a little bit more for almost an ideological vision of what the tax system should be rather than the most efficient or fair way to design health care financing.

LARRY LEVITT: Kate, let me give you an opportunity to jump in here. How do you think about the distinction between a deduction, or the advantages of a deduction, over a credit?

KATHERINE BAICKER, PH.D: A flat deduction and a flat credit share a lot of the same good health policy characteristics that they don't differentially subsidize one form of insurance over another or one source of insurance over another, but they both provide a very strong incentive to purchase insurance because you only get this deduction or credit if you're covered by a policy.

So it provides a lot of incentive to get basic insurance and then no differential subsidy for any particular kind of insurance beyond that. The big difference that Jason highlighted was that they have different distributional implications, that let's compare, just for the sake of argument, a flat credit against a flat deduction. A flat credit has recourses much more concentrated at the low end of the income distribution than a flat deduction, and that means it would translate into more people having insurance, as Jason highlighted, but then different implications for the efficiency of the tax code, say.

And so the arguments about a flat deduction versus a flat credit, I think, pit health policy against tax policy, and that's one of the hazards of doing health reform through the tax code, and I think if we weren't in the state of the world we’re in now, where we’re doing so much subsidizing of private insurance purchased through the tax code, we wouldn't want to start down that path, particularly with the implications for inhibiting movement in the labor market and the interference with job switching. But we are in that world now, and that’s why that’s our starting point. But I think there are good arguments to be made on both sides, and the flatness of each is the most important characteristic.

LARRY LEVITT: We also got some questions about the budgetary implications of these proposals, and particularly around a refundable credit and how that’s sort of scored in a budgetary sense, whether it’s accounted as a tax cut or an actual spending outlay. Those issues you faced in putting some of these plans together in the administration?

KATHERINE BAICKER, PH.D: Yes. The President’s proposal was revenue neutral over the 10-year budget window. You could equally well design a flat credit that was revenue neutral because we’re implicitly spending so much money through the tax code now, subsidizing employer-provided health insurance. If you were to eliminate that exclusion, it gives you a big chunk of money to allocate in another way. Now, the President’s proposal is revenue neutral over a 10-year budget window but not revenue neutral in each year because the standard deduction amount was set at 15,000 dollars for a family policy for the first year, and then that amount would grow with inflation. So it would grow by the amount of CPI each year, not by health care cost growth.

So it would actually lose money in some of the early years and gain money in some of the later years because it would grow with a flatter trajectory than the current projection of how much the tax expenditure on the subsidy of employer-provided insurance grows now. You can dial up a flat credit amount, dial up or down, the same way you can dial up or down a flat deduction amount to be on aggregate revenue neutral with different distributional implications.

LARRY LEVITT: And Gary, I think no one knows as much about insurance premiums and what they've been doing than you. Help us put some numbers on this. I mean, for example, how do these credits or deductions we're talking about compare to the price of health insurance, the average price of health insurance today, and also, to Kate's point, how are premiums growing, relative to inflation, if a creditor deduction like this would grow with inflation rather than the growth in premiums?

GARY CLAXTON: Well, the average cost of an employer-based insurance, the average cost of a single policy is around 42, 4300 dollars, and the average cost of a family policy is a little over 12,000 dollars. While the premium growth has slowed recently, we're still looking at basically employer-sponsored insurance, you know, practically doubling since the turn of the century. So it's been going up eight, nine percent a year earlier, and now in the six or seven percent range, so faster than CPI.

LARRY LEVITT: You talked about the average family premium and the average single premium, the family premium being roughly three times, almost three times, the cost of a single premium. And we did get a question about that about how these tax subsidies that are being proposed, for singles and families, relate to the actual cost of coverage for singles and families. And this one question we were asked, you know, that these proposals, for example, the Bush proposal and the McCain proposal, have a family subsidy or tax credit that's double that for singles, yet the premiums are actually much higher than that for families. And Jason, what do you think the effect of that would be, or is there a rational for that?

JASON FURMAN, PH.D: I think we actually need to look more seriously at family size adjustment. So there are proposals out there that would have— and these aren't the exact numbers but— maybe 2,000 dollars per adult plus 500 dollars per child, or something in that respect that adjusts for your family size in a way that's more sophisticated than just having these two numbers. And if you're the IRS, that's just as easy to do as just the two, the individual and the family sized coverage. That's all information they have. So I think we do need to do a better job of thinking through and modeling what the relative values of these, rather than picking numbers out of the air and thinking they sound nice.

LARRY LEVITT: I wonder if it’s good or bad that we don't have the IRS on this panel.

Kate, let me ask you, I mean, was it sort of purposeful on your part to have a multiplier of two, or is it just a kind of simple—?

KATHERINE BAICKER, PH.D: I think— I suspect; I can’t speak for everyone who’s put forward any of these proposals, but I suspect it was just a simplification for ease of doing initial scoring, and it seemed about right, but I doubt that there’s anyone suggesting any of these proposals who would object to the ratio more closely matching the ratio of real premiums that people face. It was an initial simplification.

JACK MEYER, PH.D: It’s what insurers use.

LARRY LEVITT: Insurers use—?

JACK MEYER, PH.D: Two to one, typically. But I think the problem is if you’re faced with a 12,000 dollar premium and you get a tax credit of 4,000 dollars, and you make, say, 30,000 dollars a year, you’re being asked to come up with 8,000 dollars to meet the difference, which is more than 25-percent of your income. You’ve got to pay the rent, put food on the table, and fill up your gas tank to get to work. It just doesn’t work for a lot of families. It’d be fine for somebody making 100,000 dollars a year. But most of the uninsured don't. They're more like the 25, 30,000 worker, which is why I think picking up 30 or 40 percent of their premium isn't going to do it. They won't take it.

GARY CLAXTON: Also having a relatively large single contribution in these proposals kind of exaggerates the coverage impact you get when you model them, because a lot of the uninsured are relatively young that don't have big incomes.

LARRY LEVITT: They fall into single versus the family.

GARY CLAXTON: Yes. So they're single and they're buying non-group coverage that's pretty cheap because of their age, and therefore you get a lot of them buying, and in some of the cases they can almost buy for nothing under these proposals. So having it relatively high is going to benefit them, and then we don't see— the older people who have families are still going to buy. They're not going to drop coverage, even if the deduction or credit is a little lower than maybe it ought to be. So I think part of it also might be to maximize the amount of impact that as a parent, when people try to model the policies. At least it has that effect. I don't know if it had that intent.

LARRY LEVITT: I'm going to come back. You know, we've been talking a lot about the premiums and subsidies for premiums and not a lot about people's out of pocket costs and how the tax system relates to that. And Kate, let me start with you. You had mentioned the idea of a standard deduction or a flat credit essentially encouraging people to purchase, or giving them an opportunity to purchase different kinds of insurance and encouraging less generous coverage. Are there tax changes that you would make along with this premium subsidy that would accomplish that goal?

KATHERINE BAICKER, PH.D: I think some of the individual insurance market reforms that we talked about would really compliment a proposal that level of the playing field, from the tax perspective, both in terms of the types of policies that are available for individual purchase and in terms of the premiums that people are charged. That said, all of this depends on having much better information about the quality of care that a plan would provide, that a physician or hospital would provide about the price of services. We rely on market competition to help generate some of the long run efficiency gains hypothesized under these proposals, and that kind of competition really can’t exist without better information. And as a corollary, I think providers could use better information to comply with best practices when we know what they are, and to figure out what best practices are when we don't know what they are.

So all of this will work much better if there are systems in place for information transfer and interoperable medical records, etcetera, etcetera. And those would augment the benefits of participating in the private market and reduce some of the administrative costs that might go along with it.

LARRY LEVITT: And how does something like a standard reduction, how does that relate to, let's say, tax-preferred health savings accounts?

KATHERINE BAICKER, PH.D: In a way, you can think of tax-preferred health savings accounts as one step in that direction and a standard deduction or a flat credit as a much bigger step in that direction. And the direction that I'm having in mind is the tax code not particularly favoring employer-provided insurance with low deductibles and low co-pays. So right now there's this strong incentive to minimize out of pocket spending that is not tax preferred. The motivation for health savings accounts was to give people a pot of money that was also tax preferred, with which to cover out of pocket spending so that it would be more attractive to have policies with, say, lower premiums and higher co-pays because the co-pays would also be tax preferred along with the premiums. But the health savings accounts go along with a high deductible policy. You are only eligible for a health savings account if you have a high deductible insurance policy that goes along with it. There's nothing magic about the high deductible policy. It's written down, you know, it must have a deductible of at least this much and out of pocket spending of at most that much, and some other features. I don't think we know that that’s the best form of insurance for people to have. So something like a flat credit or a standard deduction removes any tax bias towards any particular form of insurance and says if you buy a dollar more of insurance, it costs you a dollar more on the margin, and it can be any form of insurance you want. And I think that that then removes the tax code as an influence towards a particular form of insurance that may or may not be the best for the people who are purchasing it.

JASON FURMAN, PH.D: HSAs have a lot of very peculiar notions, but to hit on two of them that are quite important: One is they’re premised on the idea that the consumer knows best about health care, but only as long as they take a health plan that was designed by the government with a specific set of parameters that, for instance, allow you to not have cost sharing for what the government considers prevention, but maybe for chronic disease management. If you have diabetes, you do have to have cost sharing. And I think that type of top-down is actually antithetical to the philosophy that HSA proponents have and can create a lot of problems for them.

The second real peculiarity of them is you say, “The tax credit is creating all these problems for the way you spend money. So here’s what we’re going to do: We’re going to have yet another tax break, and we’re going to hope that this new tax break cancels out the old tax break and somehow we all end up in a better place.” Now, that might happen. I think in some cases it does, but you have to tune it all exactly right, and in a world as complicated as health care and taxes, you can't be sure you got that right. You might end up having people spend more money, in worse health, giving big tax breaks to high-income people. That's why, like Kate, I would agree that this other approach of leveling the playing field, not by throwing new tax breaks in, but by taking some of the existing ones out, is a much better way to go because it says if you want to save money on health insurance, the government's not going to subsidize it. It's not going to distort the form. But now you go out and figure out the best way. If it's an HMO, to save money, go to that. If it's a high deductible, go do that. If it's a high deductible with exceptions for chronic care, go do that. You figure out the way that you like best, the way that works best within the system.

If you look at estimates as to how much you'd save based on past simulations, my estimate is shifting to this type of system that would level the playing field, you'd save six to 25-percent on aggregate health spending. The congressional budget office put the savings under the Presidents plan at 15-percent. That is as large as most other ideas that anyone has in health care. When you take in a two trillion dollar system, it adds up to a lot of money. So I think there's a right way and a wrong way to save money, and I'd much rather see us scale back the distortions and the tax system, rather than add new ones in and new government regulations.

LARRY LEVITT: And can you explain, I mean, how do those savings, I mean, how do those materialize? What is it about these proposals that produce these savings?

JASON FURMAN, PH.D: Right, you need to estimate two things to project the savings: Number one, how much are people going to switch into a health plan that has a higher deductible or higher co-payments or higher co-insurance, and if you get rid of the subsidy— right now you're subsidized when you pay your premium at the beginning of the year, but you're not subsidized when you pay for health care throughout the year in co-payments and deductibles. If you get rid of that first subsidy, or at least just get rid of it on the margins, you might be subsidized for having insurance, but not for more generous insurance. You'll probably buy insurance that has higher co-payments, higher co-insurance. So one, you want to know how much higher those are, and then two, when you have higher co-payments, higher co-insurance, you end up spending less in insurance. So you need to know both halves of that equation to estimate how much it'll reduce spending. There's a lot of uncertainty around both of those, as evidence by my range of six to 25-percent, but I think we can be confident that it would make a pretty meaningful dent in overall health spending.

LARRY LEVITT: Jack?

JACK MEYER, PH.D: Well, in addition, we’re not having tremendous increases in costs because people are overspending at the front end of care. Our costs are driven by a small proportion of people who are very sick who are managing multiple chronic illnesses or have disabilities, and they would blow through a deductible or co-payments in the first couple months of their year. The healthiest 50-percent of us only account for three percent of all expenditures. It's a small proportion of people. So I think we do need cost control in this country, but I don't think we’re going to get it by raising deductibles. And there are pretty significant deductibles in the system today, even in employer coverage. And the danger is that faced with these higher deductibles, workers and their families will give up needed front end services and end up costing us more, and having tragic health outcome.

LARRY LEVITT: Gary, you know, often in these discussions about the effects of cost sharing, people turn back to the one study that told us something about this, which was the RAND Health Insurance Experiment. Can you give a— I hesitate to ask you to so this, but— give a very quick summary of what you think the RAND Experiment tells about the effects of cost sharing?

GARY CLAXTON: The RAND Experiment randomly put people into different types of health insurance policies with different levels of cost sharing, and then looked at how much health care they consumed over a period of, I think, three years. And then they followed their health a little bit farther than that and found that generally people with higher cost sharing consumed much less care than people who had no cost sharing and that with some small exceptions there were not differences in their health outcomes, based on the cost sharing. One of the important caveots to that though is that everyone had a realativley low out of pocket maximum on their cost sharing, relative to what we see today, and sort of another caviot is that the amount of preventative care that we have today and some of the treatments for chronic illness that we have today were not necessarily as available then. So ther are reasons to at least be cautious about just always extending it as gospel, but it is certainly the best piece of research out there that would show that cost sharing will reduce expenditures, and for many people it won't affect their health alot.

For people who start out in poor health and low income, there were some bad health outcomes, if I remember. Is that right?

JASON FURMAN, PH.D: Yes. No, that’s right.

LARRY LEVITT: Well, we’re coming close to the end of the hour, and I want to make sure we get to a question that a lot of people asked, which is what’s going to happen. [Laughs]

And a lot of people were interested in what this panel of experts thought might happen this year or next year. I just want to give you all an opportunity to address that, and, you know, in particular, I mean, is there, in an election year like this is there a potential for any change in the tax code and health insurance? And then looking forward to 2009 and beyond, what are the prospects for the health reform plan that might include, or what are the prospects for an inclusion of some kind of changes in the tax code in potentially a broader debate or plan. And Jack, you're nodding your head, so I'm going to give you the first opportunity.

JACK MEYER, PH.D: Well, I don't think much will happen years divisible by four that have February 29, but looking ahead to next year, I think there's some convergence of opinion that we can combine something between a single payer system that's not bad, on one hand, and small tweaks in the current system with a few incentives on the other. And that will involve some limited expansion of our public programs to people in need who are left out; some kind of risk pooling arrangmetns maybe at the state level; some kind of employer obligation, maybe not a full payer play; probably some kind of individual obligation not to be a free writer. And this is going to cost some money. And I think reforming the tax system and putting some limit on the exclusion could be one of the financing sources. The others are pretty unpopular, and this one may be too, but I think it's in that context that it'll be brought up, when people realize the cost of health reform and say, "Where could we get this money that isn't a big tax increase on all Americans, or at least middle and lower income Americans?" They may turn to this.

LARRY LEVITT: Well, Kate, I don't want to put words in your motuh, but I'm guessing you might have a slightly different answer.

KATHERINE BAICKER, PH.D: Well, I am encouraged by the fact that people are takig potential reforms of the tax codes so seriously. I think five or six years ago we might have said, "Oh, no one will ever take on the current employer exclusion. It's just not on the table to change that to try to finance more efficient use of health recourses and broader coverage." And people aren't saying that anymore, so I do find that encouraging. But in terms of what's going to happen, I certainly have no idea, [laughs] and as an adademic economist, it's very interesting to sit back and watch how these play out in the political spectrum, but I would hesitate to offer any forecasts.

JASON FURMAN, PH.D: Anything that happens on health care, I think, will accord a central roll to taxes, because policy makers love tax cuts as a solution to the problem, whether that's the right way to design it or not the right way to design it. And virtually every one of the major proposals out there has taxes as a big part of it. The question though is is that going to be new tax subsidies, is it going to be expanded health savings accounts, or is it going to be the type of policy we've been talking about where you take the existing tax exlclusion and curb it or eliminate it and replace it with something else. That latter is certainly a lower proability event. One thing that's encouraging though is there are 12 seneators— six democrats and six republicans— who support an approach along those lines, and it's something that several of the presidential candidates have talked about moving partly or fully in that direction. So there's a certain amount of momentum around it, and ulitmatley, if we're going to have a big health reform, it's going to be really, really expensive. We're going to need to find a way to pay for that health reform, and it's not going to take long for people to notice that there's this pot of 200 billion plus dollars that they might be able to reuse, at least in some way, to help pay for that reform.

LARRY LEVITT: And I assume the bill you were talking about was the Senator Wyden's—

JASON FURMAN, PH.D: Yes.

LARRY LEVITT: —plan, and is that, I mean, do you have a sense that there's more of bipartisan support for these kind of ideas than there used to be?

JASON FURMAN, PH.D: I don't think there have ever been, and I don't know. Somebody who knows political history better than me might know, but I can’t imagine there have ever been 12 senators on the record supporting this idea. I would be surprised if there had been three senators on the record supporting this idea in the past.

GARY CLAXTON: And the senate finance committee just announced they’re going to start doing a series of bipartisan briefings on the current tax exemption and tax treatment of health insurance as part of raising awareness, and these are all things we didn't see a few years ago, and because, as Jason pointed out, how expensive everything that we have to pay for now is, probably people won't want to start here, but they may come back to having to think about this as they think about revenue.

LARRY LEVITT: Well that sounds like a good place to leave this, and I’m sure we’ll be back. I have no doubt we’ll be back talking about these and similar issues.

Larry Levitt, and you’ve been watching kaisernetwork.org. Thanks to our panel of experts, and thanks to all of you for joining us. We’ll see you next time for Ask the Experts.

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