
Assessing Employment-Based Insurance and its Alternatives

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To no one's surprise, Stuart Butler has done about as good a job as can be done presenting the case that a system of individual tax credits could be fashioned to replace the current employment-based health insurance system. Unfortunately, as good a job as can be done is not good enough.

To begin, I want to stress that the current system of employment-based health insurance is not one any of us would have designed and recommended. It arose initially as an accidental by-product of wage controls during World War II. Those controls prohibited wage increases but permitted new or expanded fringe benefits. Under super-intense demand for labor, employers competed with the only coin they could freely spend and attracted workers by offering health insurance and other fringe benefits. Tax law excluded the value of such benefits from taxable compensation, and we were off to the races. The combination of the tax advantages — less important during the war and in the years immediately thereafter than they are today — and the economies of group administration and pooling gave work-based insurance an enormous advantages over other methods of buying health insurance.

Through historical accident we have evolved to a situation in which 168.8 million people are covered by employment based insurance. We are all aware of the disadvantages of this system. Linking health insurance to employment can tie people to jobs at which they would not otherwise remain. It can confront involuntary job losers with a loss of health benefits as well as a loss of income. It causes costs to

vary across companies because of the age, sex, or race of the work force. These factors should not influence relative commodity prices or employer profits or, I would argue, amounts of other employee compensation. It absorbs the time of business executives who are not expert in health insurance or health care and whose time is better devoted to making goods and services efficiently and cheaply. And it can have other undesirable consequences as well. Virtually all health economists have been aware of these shortcomings for as long as they were economically literate. None of us would pick employment-based coverage if we were designing a health insurance system from scratch. But we have been prepared to stick with employment-based coverage because it was doing a pretty good job of covering the population, and nothing else seemed likely both to work and to win political approval.

Now, it is alleged, both those reasons to stick with employment-based coverage have been undercut. Critics of the employment-based insurance claim that it is falling apart. And, supporters of the alternative system based on tax credits claim to have answered the objections most often raised against this alternative. I believe that both of these claims are false. The current employment based system of health insurance remains as flawed as it has always been and would top none of our lists of favorite designs. But it is not falling apart. And tax-credit-based alternatives continue to court serious risks that I think are not worth taking.

Let us be clear on the fact that the current system of employment-based health insurance has huge positive achievements to its credit and — this will be more controversial — although subject to serious strains, it is not falling apart. It covers two-thirds of non-aged adults. Furthermore, coverage is expanding rapidly. The employment-based system had a pretty dismal record from 1987 through 1993, years during which the economy performed reasonably well, but not outstandingly. But for the gradual expansion of

Medicaid coverage, the total number of insured would have fallen, at least if one ignores the possible trade-off between Medicaid and private coverage. Population rose 18 million over that period, but employment-based coverage actually declined by about 1.4 million. The number of uninsured rose by just under 10 million.

In the last four years, however, the picture has changed dramatically. Population rose by about 9.5 million and employment-based coverage rose by just under 9 million. The increase in the numbers of uninsured almost matches the decline in Medicaid coverage. This picture does not tell the story of a failing employment-based health insurance system. It tells the story of a health insurance system that does well when the thing to which it is linked — employment — is expanding rapidly and unemployment is low. It tells the story of a public backstop system that is eroding in part because of the movement of poor people into the labor force and in part because potentially eligible families increasingly are failing to learn of — or be informed about — their eligibility for Medicaid. Of course, recessions are not things of the past and will recur. We can hope, and even expect, that they will not be as severe as they have been in the 1970s and 1980s, but there are no guarantees. When unemployment rises, the growth of employment-based coverage will be interrupted or slowed. As I have stressed, this linkage between health insurance and employment is undesirable. I believe that we should work to make sure that it is broken. But the desirability of the goal does not mean that any means is sufficient.

In particular, we should make sure that any proposed alternative system does as well as or better than the current system. And we should be clear what that means. An acceptable reform must increase total health insurance coverage. And it must not result in the loss of coverage by significant numbers of the

currently insured. I believe that the tax credit proposals examined by Mark Pauly and Bradley Herring and by Stuart Butler fail those tests in a major way. Here is why.

Current employment-based health insurance promotes coverage in three ways. First, the exclusion of employer-financed premiums from federal income and payroll taxes and from state income taxes reduces the cost of health insurance to households relative to other forms of consumption financed out of taxable cash wages. Second, pooling at the work place reduces administrative costs. Third, pooling at the work place reduces problems of adverse selection.

Tax credits linked to voluntary purchase of insurance would probably reduce total coverage unless the credits were so large that they reduced federal revenues more than is likely to prove acceptable. Employers who now are conflicted about retaining health insurance would find a decision to get out of the health insurance business far easier than it now is. Stuart Butler wants to mandate that employers raise wages by the amount they save in health insurance premiums, but he doesn't say how he would enforce such a requirement. But standard economic theory suggests that total compensation would likely change little and that cash wages and other compensation would rise to offset reduced outlays for health insurance. I am prepared to believe that workers on the average would indeed see increased compensation, but I am also rather sure there would be some big gainers and big losers. More importantly, the increase in wages would not be linked to health insurance.

Under these circumstances many workers would elect not to buy insurance for the very reason that most workers employed by companies that do not offer coverage do not buy insurance on their own. Other groups might form, but there would be a powerful incentive for good risks to form groups, leaving bad risks to pool separately or not at all. Those of the formerly insured who did not find their way into new groups

would face dramatically higher loading charges. No analysis has been done that carefully evaluates what employers would drop coverage and what workers in such companies would do.

The Pauly-Herring analysis is no exception. It is limited to full time workers. It assumes that the choice to buy insurance is a purely economic matter, so that those workers' decisions to buy insurance depends only on cost, not on whether employers provide plans. But settings and defaults matter greatly, as indicated by experience with pensions.

To appreciate the importance of seemingly small institutional considerations, the experience following enactment of ERISA is startling. Before ERISA, single-life annuities were the default. Following ERISA, 50-percent-joint-and-survivor annuities were the default. But workers could elect the alternative simply by checking another box. This shift was associated with a jump from 48 percent to 64 percent in the proportion of men electing joint-and-survivor pensions.

If employers cease to be insurance sponsors, workers' voluntary purchase of insurance is quite likely to fall, even if their net costs are unaffected. Of course, they are likely to be affected massively. To the extent that workers form small groups, administrative loads will rise. To the extent that low-risk workers group into pools of their own, high-risk workers will face increased premiums. Limits on underwriting could mean that insurance was unavailable. Furthermore, even if one confines one's analysis to the full-time employed and even if one is prepared to blow-off factors other than price as irrelevant to the insurance purchase decision by saying "While determining these 'other reasons' would be highly useful research, we assume here that the distribution of reservation prices is given" (Pauly-Herring, page 7), it takes credits of as much as 50 percent of premiums according to their calculations to make a major dent in the population of uninsured. And a 50 percent credit would massively lower federal revenues

necessitating a large increase in tax rates to maintain revenues for other purposes, a change that Pauly and Herring assert falsely (page 10) would not result in inefficiency. For reasons I shall come to presently, the 50 percent credit is most unlikely to produce effects as large as Pauly and Herring suggest.

Stuart Butler recognizes that a shift to tax credits threatens implosion of the market for insurance. Accordingly, he links his credit to a mandate that individuals purchase insurance. Let's begin by acknowledging that we can achieve universal coverage independent of the work place if we are prepared to enact and to enforce a mandate that every person must have insurance. It is far from clear, however, that we would have the stomach to enforce such a requirement and the enforcement problems could be severe unless the credit was quite large, probably in excess of 50 percent. Such credits would require large income tax rate increases to maintain revenues.

But let's leave those issues aside. Advocates of tax credit finance for mandatory individual purchase of health insurance deal in what Stuart Butler labels "An Alternative Vision." The word A vision is a bit troubling because it evokes images of dreamers contemplating an imaginary world. One does not need real facts to support "visions" — imagined facts will do. And, of course, one can focus on pretty images to the exclusion of nasty possibilities.

To understand the source of what I think are some nasty possibilities, I want to focus on how pools would be formed in a tax credit system. Let's be frank — I don't know. Stuart Butler doesn't know either. But he can dream —and he does. Pooling would occur, he suggests through affinity groups, including, but not limited to "churches, unions, school associations, elderly organizations, tribal groups, and similar bodies." He imagines "a surge of new ventures by existing corporate plans, reminiscent of similar patterns

when restrictions were removed for spin-off ventures in other industries.” A core question: should each person be expected to pay annually the expected cost of his or her medical expenditures?

Well, maybe. But the same hormones that produce visions can also produce nightmares. I envisage insurance entrepreneurs who aggressively identify low-risk customers who are dowered with the same age-sex-region based premiums as the rest of us and who carve them out from the rest of the population by making these good risks offers they could not possibly refuse. Where Butler sees churches, unions, school associations, and a flowering of insurance entrepreneurs, I see a flowering of non-insurance organizations who select members on the basis of the same criteria that insurance underwriters use to set premiums.

A good candidate right here in Washington area would be the Potomac Peddlers Touring Club, a bicycle club of which I have long been a member for twenty years and whose ranks, I am willing to bet, include much lower-than-average health risks. We could go to an insurer who would engage in no underwriting whatsoever, and we could get a pretty good deal — extra health benefits, new bicycles, or discounts on any of the wide range of services that will be provided by the financial conglomerates that can be formed in the brave new post-Glass-Steagall world now aborning. There is nothing in the tax credit plan that Stuart Butler has described to prevent this highly lucrative activity, and I am enough of an economist to believe that if one leaves \$500 bills on the street, someone will pick them up. Assuming that someone did so, other groups would become much-higher-than-average risk pools. The result would be high cost plans or none at all, unless one regulated the industry aggressively. I do not see heavy regulation of health insurance as a big plus, but it is an inescapable consequence of a tax-credit based system.

I want to conclude by calling into question one of the “facts” that Stuart Butler, Mark Pauly, and many others take for granted. They and others report that the value of the exclusion of employer financed health insurance premiums rises with income. This view is not correct for two reasons.

First, many low income household are in the phase-out range of the earned income tax credit and face higher tax rates than does even the wealthiest taxpayer. Many such households lack work-place based health insurance. Consequently, the value of the exclusion of employer-financed health insurance *averaged* across all low-income households is not high. But the value of exclusion to low-income households who have such insurance can be greater than the value to any other households. In particular, for a hypothetical family with two children, subject to a marginal personal income tax rate of 15 percent, a payroll tax rate of 15.3 percent, a marginal state income tax rate of 5 percent, and the phase out tax rate under the earned income credit of a bit over 21 percent, a tax credit of 56 percent would be required to hold such a household harmless under the Butler plan.

The second reason why the value of exclusion of employer-financed health benefits does not rise with income is that the payroll tax does not apply above earnings of \$72,600. At that income level, the marginal federal personal income tax rate is 28 percent. Higher earners face personal income tax rates that may rise by as much as 11.6 percentage point, but they typically cease being subject to payroll taxes of 12.4 percent (the Medicare tax continues). I assume that in most couples with high incomes both spouses have earnings, causing payroll taxes on couples to continue above \$72,600 of family income, but that not all earnings are subject to tax once a couples income reaches \$100,000. For many upper middle income couples, a credit rate much below 50 percent would provide a smaller economic incentive to buy health

insurance than does the current exclusion. Even if one takes the view that price is all that matters, the incentives to buy insurance would decline for many.

I do not pretend that this is a complete picture. But it is important to recognize that replacing the current exclusion with a revenue-neutral credit would reduce economic incentives to buy insurance for many households. The reason is that credits would go to many households who are now uninsured or who derive less-than-average benefit from the current exclusion. I believe that this situation would imply serious enforcement problems. A credit that equaled the value of the current exclusion for most currently insured households would greatly reduce federal revenues. Much of the added cost would go into windfalls for households. Some would flow to the coffers of state and local governments whose income tax revenues would swell. And some of the revenue — \$40-50 billion a year — would flow to the Social Security and Medicare trust funds. I should perhaps thank Stuart Butler for a proposal that will do much to balance the books of a program I like and he doesn't, but as Harry and Louise once said, "There has to be a better way."