Title
Reforming the Tax Preference for Health Insurance

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Reforming the Tax Preference for Health Insurance

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Insurance and moral hazard

- Insurance improves welfare by reducing risk

- Insurance reduces welfare through moral hazard
  - Depending on co-pay, insured may pay $.20 for $1 worth of services
  - Insured has an incentive to demand $1 of services that she values at < $1

- Expectation: insurance would be bought to prevent uncertain, high cost outcomes (and/or in areas not subject to moral hazard)
  - E.g., car or homeowner insurance with high deductible
Employer-sponsored health insurance (EHI) is deductible by employers but exempt from payroll and income tax
- Value of exemption is roughly $.32 on the dollar
- Approximately 85 million returns, budget cost of exemption is $246 billion (JCT, 2007)
- This is the largest single tax-preference in federal budget – including retirement savings and mortgage interest

OOPS is deductible only against income tax, only if taxpayers itemize, and then only to extent it exceeds 7.5% of AGI
- Approximately 11 million returns, budget cost of deduction is $9 billion (JCT, 2007)
Health Savings Accounts (HSAs)
- Allow taxpayers to deduct amounts used to pay medical expenses on high deductible/copay plans.
- This effectively increases OOPS deduction, reducing tax preference
- Limitations
  - Applies to only 534,000 returns, budget cost $334 million (JCT, 2007)
  - Requires additional taxpayer planning to set up plan

State taxes
- States give same preference to EHI, thus increasing total preference by roughly 10%
EHI Exclusion is generally described as reducing cost of medical care by tax rate so taxpayers pay only 68% of the cost of medical care, increasing spending.

But tax code also funnels medical spending into EHI and away from OOPS.
  - This, too, increases spending since EHI is subject to moral hazard.

Current law thus distorts two margins simultaneously: medical v. other spending and OOPS v. EHI.
Americans get health insurance through their employer, and according to most health policy analysts, get more generous insurance than they otherwise would.

But by leading people to get more generous insurance, the tax subsidy for EHI also leads to more moral hazard:
- additional moral hazard is likely an important part of health care spending growth.
Is across-the-board subvention of health costs desirable?

- Characterizing effect of current law as “distortion” suggests (correctly) that we don’t think there is a Pigouvian rationale for this subsidy.

- RAND study randomly assigns persons to policies with varying copay and deductible.
  - Main result (Gruber, 2006) For average, non-poor individuals, lowering copay increases spending but does not produce measurable improvements in health.
  - Consistent with intuition that at the margin, for this population, subsidy is used to purchase non-essential services that are not valued at their cost.
Targeted subsidies

- Subvention is only way to provide medical care to poor
  - Not surprisingly, RAND study shows it improves health outcomes
- Subsidies might make sense for individuals with certain markers of ill-health (e.g., high blood pressure) or other characteristics
Approach of paper and proposal

- First-best solution would be to eliminate across-the-board tax subsidy
  - Politically unfeasible
    - Fate of “Cadillac Plan” health tax in recent Senate bill underscores the problem

- We focus on more realistic sub-goal: reduce waste (and overall medical spending) by reducing the distortion between EHI and OOPS
Allow income (but not payroll) tax deduction for OOPS
  - This reduces the relative subsidy for EHI over OOPS
    - Taxpayers substitute away from low copay/deductible plans that are inefficient due to moral hazard
    - This reduces health care costs and waste

But it increases overall subsidy to health expenditures (since preexisting OOPS expenditures are now deductible)
  - This increases health care costs and waste
Health care costs decline by between 2.7 and 9.5%, with 6% as midpoint estimate.

In absolute dollars, this comes to $61 billion/year (2008)
Intuition behind CHK result

- Most spending is now done inside inefficient, low copay EHI
  - At the margin, taxpayers may pay 10x for services worth only 9x
  - Reducing the relative tax cost of OOPS (by giving it a subsidy almost as big as EHI) allows those taxpayers to switch to OOPS, spending 9x instead of 10x

- Deduction for OOPS increases that portion of OOPS that doesn’t come from switching out of EHI, but that is a small portion of total spending
Midpoint estimate of CHK is $10 billion/year (2008)

Cost arises because while CHK reduces total medical spending, more of spending is now deductible (because pre-existing OOPS is now deductible)

Costs represents a transfer payment, not welfare loss (though higher taxes will produce some welfare loss)
There are some equity-related benefits

- Current law advantages relatively wealthy taxpayers with “Cadillac Plans” over poorer taxpayers with higher proportion of OOPS
- CHK reduces this disparity
Increase in filing burden

- CHK requires taxpayers to track and report their OOPS
- This requires (at a minimum) retaining year-end reports from pharmacies and doctors
- Taxpayers and others (e.g., IRS, pharmacies that issue year-end statements) may spend time on distinction between OOPS and non-medical expenses
  - This was a hotly contested issue prior to adoption of 7.5% AGI floor
- At 2hrs/yr per family, this might be 1B/yr cost
A closely related reform can achieve the benefits of full deductibility without the drawbacks:

- Instead of allowing people to deduct their *actual* OOPS, give them a *fixed* deduction for their *expected* OOPS, conditional on the terms of their insurance policy.
- This avoids any increase in filing burden.
- More importantly, it leads people to seek policies with higher deductibles and coinsurance rates, but not to expand their health spending on the extensive margin due to the (otherwise) open-ended deductibility of OOPS.
How it would work (I)

The fixed deduction for OOPS is easy to calculate:

- Have to buy a plan that meets minimum criteria of insurance
- Plans are commonly characterized by their Actuarial Value (AV): the share of health spending that the plan would have paid, had it been covering a standardized population with standardized medical spending levels
- AV = 1 – the effective coinsurance rate $c$
- Since premium = $(1 + \text{load}) \times AV \times \text{spending}$,
  
  \[
  \text{expected OOPs} = \frac{\text{premium} \times (1 - AV)}{(1 + \text{load}) \times AV}
  \]
Dorn (2009) explains how standardized AV’s could be calculated by IRS
Consider the effect of CHK on a hypothetical taxpayer, Amy, who has a Cadillac plan

- She chooses (or with others causes her employer to choose) a plan with a higher coinsurance rate $c$.
- She expects to receive an OOPS deduction worth $D$.
- Her actual deduction will vary with her actual OOPS, which may be more or less than her expectation.

Relative to CHK, a fixed deduction worth $D$ would have two effects

- It would raise the relative price of OOPS (which would no longer receive a tax subsidy), holding constant the overall price of health care, leading OOPS to decline.
- It would lower the overall price of health care (insured plus OOPS), holding constant the relative price of OOPS, leading overall spending to decline.
Except for the fact that Amy is slightly less protected against the risk of high OOPS (discussed below), she would prefer the fixed deduction to CHK

- To get $D$ under CHK, Amy must buy some OOPS that, absent the open-ended deduction, she would prefer not to have
- Now, she can get $D$ without buying the extra OOPS she does not want
- If she then decides to lower her health spending further, that must make her even better off
CHK offers Amy one advantage that this proposal lacks. Under CHK, the OOPS deduction will rise with ill-health. Thus, CHK contains an insurance element.

In spite of this, Amy is almost certainly better off with a fixed deduction than with CHK. Since most plans waive copays for truly serious illness (i.e., have out-of-pocket maximums), the value of this insurance element is unlikely to be large enough to offset the otherwise more attractive feature of this proposal.
In addition, the fixed deduction leads to greater government revenues than CHK

- Fixed deduction is budget-neutral relative to CHK re: the OOPS deduction.
- Fixed deduction is budget favorable relative to CHK re: the employer-sponsored insurance exclusion: fixed deduction leads to a decline in health spending, over and above the decline in OOPS.

Thus, the fixed deduction (almost surely) makes everyone better off!
The additional reduction in spending is the sum of two effects:

- Holding $c$ constant, OOPs would decline, because OOPs would not receive a tax subsidy
  
  $\Delta \% \text{ spending} = \text{OOPs share of spending after full deductibility} \times \text{change in price of OOPs from full deductibility} \times \text{price elasticity of health spending} \ e$

- Total spending would decline, because the effective price of health care (insured plus OOPs) would rise
  
  $\Delta \% \text{ spending} = \Delta \text{ effective price of health care} \times e$

  $= a \times t \times e$
Additional Δ% health spending = $2 \times a \times t \times e$

$= 2 \times 0.33 \times 0.15 \times e$

Which is between 0.02 and 0.07…

… so, using calculations from CHK (2007), full deductibility implemented with a fixed OOPs deduction would lead to a decline in distortionary health spending of 4.7% to 16.5%, with 10.6% as midpoint estimate!
This reduction is about 50% greater than that predicted in CHK (e.g., from 2.7% to 4.7% using low elasticity estimate of .2; from 9.5% to 16.5% using high elasticity estimate of .7)

In absolute terms, the implies an annual reduction in health care spending between $40B and $140B.
Future Work

- Budget implications of a fixed versus OOPS deduction

- Generalization of the idea
  - Why limit payment to expected OOPS?
  - How large would the payment have to be to completely undo the distortion effects of EHI exclusion?