PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

COVERAGE DENIED

ISSUE BRIEF PART FIVE

Establishing An Efficient Health Insurance Market

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Executive Summary

Cultivating an efficient health insurance market requires reforms that empower patients over payers, which can be achieved by:

- Making health expenditures and health insurance expenditures tax deductible;
- Broadening the availability and usability of tax-free saving accounts to help patients cover the deductibles and out of pocket expenses that could arise should they require costly healthcare services; and
- Promoting price transparency and insurance competition to enable a more competitive pro-patient healthcare environment.

Overview

The first half of the *Coverage Denied* series connected the disincentives of the U.S. health insurance system to many of the healthcare system's inherent flaws. These flaws disempower patients and create ineffective health insurance that fails to manage the risks from exceptionally large medical bills. Just as troubling, these financing deficiencies increase overall healthcare costs and worsen the quality of healthcare for patients.

Correcting the defects in how healthcare is financed can improve healthcare delivery, promote greater affordability, and efficiently mitigate the financial risks from costly healthcare services. The next four papers in the *Coverage Denied* research series will discuss beneficial policy changes that could help achieve these goals.

First, reforms should eliminate the disincentives that pervade the current health insurance market. Policies should stop subsidizing the current third-party payer system—which is centered around employment-sponsored healthcare coverage—and empower patients instead. This will require tax code changes to create tax parity between individual and employer health insurance costs, establishing a transparent pricing system for healthcare, and enabling patients to control how and where they spend their healthcare dollars. This paper (#5) discusses these issues.

Second, reforms must fix the bizarre drug pricing system that inequitably transfers costs to patients and encourages the use of more expensive medications when less expensive, but just as efficacious, alternatives exist. These reforms should focus on minimizing the complexity and opacity of the current drug pricing system and, ideally, empowering novel approaches for providing coverage. Paper #6 will address these issues.

Third, healthcare reform should eliminate the regulations that disincentivize innovation in the provision of medical services, which is the topic of paper #7. Excessive regulations make it difficult for providers to meet the needs of patients today and develop innovative patient-focused delivery models that provide higher quality care for less cost tomorrow.

As part of this process, it is essential to encourage payment model innovations, especially considering the anti-innovation biases inherent to the dominant fee for service payment model. Freeing up providers to offer patients more choices is an essential complement to the reforms that empower patients with greater control over their healthcare expenditures.

Finally, there is a critical need to improve access to healthcare services and increase the quality of care for individuals and families with incomes too low to pay for healthcare and/or afford adequate health insurance services. To meet these goals, it is essential to address them as a separate question from healthcare reforms or reforms to the health insurance system. At its core, addressing the problem of insufficient income is an issue of establishing efficient income support programs, which requires establishing a more effective social safety net. Addressing the income support issue (e.g., reforming the government-driven/socialized portion of the healthcare system) is the topic of paper #8.

While the series of papers discuss each reform individually, and there could be political benefits from implementing these reforms in piecemeal, comprehensive reforms will maximize potential savings and benefits.

From Prepaid Care to Efficient Health Insurance

As the *Coverage Denied* series has documented, it is a misnomer to call the current healthcare financing system "health insurance" when judged against the service as commonly understood. Instead, this alleged insurance system operates as a suboptimal form of prepaid healthcare. It is suboptimal because the expenditures are prepaid to a third-party payer, which creates a wedge between the patient and provider.

Thanks to this wedge, adverse incentives plague the healthcare sector that,

- Inappropriately deny care to patients,
- Reduce healthcare quality,
- Increase healthcare costs,
- Expose patients to large financial risks, and
- Contribute to the excessive waste in the system, which studies have estimated to be between 25 percent and 30 percent of healthcare spending.[1]

Due to this causal relationship, efficient health insurance reforms that minimize the wedge will meaningfully lessen these adverse outcomes. Eliminating the healthcare wedge requires policies that empower patients to serve as the effective demand-side of both the health insurance and healthcare markets. Empowering patients, and consequently diminishing the influence of third-party payers (both private and public), starts with reforms that stop incentivizing employer-paid insurance.

Eliminating the incentives for employer-paid insurance requires changing the tax policies that distort the relative costs of health insurance depending on who pays the premiums. Currently, the tax code reduces the cost of purchasing employer-paid health insurance relative to the cost of health insurance purchased by individuals.

To see the distortions created by the tax code, consider the different costs employers face when directly providing health insurance to their employees, compared to the costs they would have to pay to enable employees to purchase this same amount of health insurance services on their own. According to the latest employer survey by the Kaiser Family Foundation, "the average annual premiums for employer-sponsored health insurance are $7,739 for single coverage and $22,221 for family coverage."[2]

These are the amounts employers pay, on average, to provide health insurance benefits to their employees. These are not the amount employers would have to pay if the goal was to give their employees the purchasing power to buy the same amount of health insurance services on their own.

If employers shifted the health insurance costs to their employees, the expenditures of the business would become income to their employees that would be "in addition" to their current salaries. Therefore, before employees could purchase health insurance benefits, the government would tax their additional income at their top marginal income tax rate (which depends on their income). For single individuals in the 10 percent marginal income tax bracket, they would each need to receive $8,599 in gross income to have $7,739 in additional after-tax income and be able to purchase the health insurance services they currently receive. For employees with families in the top tax bracket, the company would need to provide $35,271 in extra income for the employee to have $22,221 in additional after-tax income and be able to purchase the health insurance services they currently receive.

TABLE 1
ADDITIONAL COMPENSATION REQUIREMENTS THAT ENABLE EMPLOYEES TO HAVE THE SAME HEALTH INSURANCE PURCHASING POWER AS THEIR EMPLOYERS

	AVERAGE EMPLOYEE HEALTH INSURANCE COSTS		COMPENSATION REQUIRED FOR EMPLOYEES TO PURCHASE INSURANCE		COST GAP BETWEEN EMPLOYER-PROVIDED INSURANCE AND DIRECT EMPLOYEE PURCHASE OF INSURANCE	
2021 Average Employer Premium	Individual $7,739	Family $22,221				
Tax Brackets			Individual	Family	Individual	Family
10.0%			$8,599	$24,690	$860	$2,469
12.0%			$8,794	$25,251	$1,055	$3,030
22.0%			$9,922	$28,488	$2,183	$6,267
24.0%			$10,183	$29,238	$2,444	$7,017
32.0%			$11,381	$32,678	$3,642	$10,457
35.0%			$11,906	$34,186	$4,167	$11,965
37.0%			$12,284	$35,271	$4,545	$13,050

Source: Author calculations based on 2021 premium data from Kaiser Family Foundation

Thanks to the tax deductibility of health insurance expenditures for the company, employers directly purchasing health insurance on behalf of their employees can spend, depending upon the coverage (individual or family) and income, between $860 and $13,050 less per employee while still providing a compensation package to their employees that is of equivalent value.

The tax-created price gap significantly alters healthcare incentives. Due to the tax deductibility for businesses, companies purchase health insurance with pretax dollars that significantly lower the costs relative to the costs of empowering individuals to acquire health insurance on their own. The unsurprising result is the dominance of the employer-provided health insurance model. Due to this incentive, nearly 82 percent of people with private health insurance receive insurance through their employer.[3]

As we documented in Part 4, this model disempowers patients with respect to their choice of health insurance coverage. The first half of the *Coverage Denied* series analyzed the adverse impacts from this tax distortion. Many other analyses confirm that the distortions created by the tax system impose detrimental impacts on the U.S. healthcare system.[4]

Closing the effective price gaps between company-provided insurance and insurance purchased by an individual is an essential element of empowering patients over payers. Eliminating the price gap requires creating tax parity between individual and employer health insurance costs. There are two ways to create tax parity – eliminating the tax benefit for employers or expanding the tax benefit to individuals.

There is no inherent reason to exempt from taxation the health insurance benefits portion of employees' compensation. It is no more logical for employers to directly pay the health insurance expenses as part of their employees' total compensation package than to pay their employees' utility costs, housing expenses, or automobile insurance. The subsidization of employer-provided health insurance is an outgrowth of the wage and price controls implemented during the second World War, however, and this way of paying employees is embedded in the current compensation system.

If designed from scratch and without any need to consider legacy and transition impacts, then a tax system that treated all compensation as equivalent would have a great deal of merit. To facilitate stronger economic growth, tax reform would expand the tax base and lower the tax rate (ideally implementing a flat rate tax). Imposing the lowest possible tax rate on the widest possible tax base is the hallmark of an efficient tax system that promotes strong economic growth and would, simultaneously, remove the price distortions harming the insurance market.

However, transition impacts matter. Given the legacy constraints, reforms should enable individuals to deduct their health insurance and healthcare expenditures from their adjusted gross income (AGI) when filing their taxes.

Allowing individuals to deduct the cost of health insurance from their AGI eliminates the cost differential between employer-purchased insurance and insurance that individuals directly purchase. Employers can pay the average cost for an individual or family plan directly or pay their employees' additional income that gives them the resources to purchase the exact same amount of health insurance services.

Equalizing costs between the two payment alternatives does not force any change on the system. However, it fundamentally alters the underlying incentives. Having the ability to purchase insurance for the same cost as their employers, coupled with the average job tenure for today's workforce of just over four years,[5] incentivizes employees to purchase their own health insurance. Due to the large administrative burdens associated with managing health insurance plans and the relatively short average tenure, employers are incented to empower employees to purchase their own health insurance as well. With newfound control over their own insurance, employees can tailor the coverage toward their own family's needs rather than the needs dictated by their employers' human resources department.

Removing the disincentives for almost 155 million people from purchasing their own insurance creates significant positive incentives for a robust individual market that is responsive to patient needs and desired

coverage. Thus, on the supply side, health insurers' incentives have fundamentally changed as well. Insurers would have to convince individual policyholders to choose their insurance services and risk losing potential business opportunities if they provide policyholders with sub-par services or egregious access requirements. Therefore, competitive markets incentivize insurers to offer products that patients demand, which meet their medical and financial needs.

For instance, as documented in Part 1, there are too many instances of health insurers currently denying coverage for in-network claims or emergency room visits.[6] In one case that was documented, Anthem implemented rules that held patients responsible for the cost of emergency room visits if, after review, the insurer concluded that the situation was not an emergency after all.[7] United Healthcare, which is the largest health insurer in the US, adopted Anthem's policy based on the justification that it would help hold down healthcare costs.[8]

Patients controlling the premium dollars have recourse if insurers implement policies that devalue the health insurance services they receive—the ability to choose a different insurer. By denying premium revenues to insurers with policies that violate reasonable service expectations, patients can now directly express to insurers which policies they value and which they do not.

Reforms that improve the competitiveness of the health insurance industry would bolster the positive impacts from empowered patients. Take the restrictions preventing more robust interstate insurance competition as an example. As Pope (2021) noted, "the large economies of scale associated with many healthcare services make competition across state lines essential to the efficient provision of medical care."[9]

Although interstate insurance operations in the individual market are technically allowed (they have always been available in the employer market by definition), the need to establish large provider networks coupled with the obstacles created by Affordable Care Act (ACA), particularly the community rating regulations, severely diminishes the potential.[10] With respect to the ACA obstacles, reforms that enable actuarially accurate pricing to emerge are necessary to further expand the benefits from empowering competition. As Pope (2021) noted,

> The structure of the ACA-regulated individual market, which depends on a delicately balanced risk pool, maintained by a combination of state-managed subsidies and regulatory cross-subsidies between plans, is therefore likely to be incompatible with vigorous competition across state lines. Such competition is therefore likely to require the reestablishment of an insurance market where plans may be priced in proportion to individuals' medical risks.[11]

Therefore, improving insurance competition both within and across states requires reforms that moderate the regulatory burdens and reduce the number of mandated benefits that insurers must cover. The goal of reform should be empowering consumers to choose the insurance benefits they value and enabling insurers to provide them.

Foster Innovative Models for Delivering Care – A Demand-side Perspective

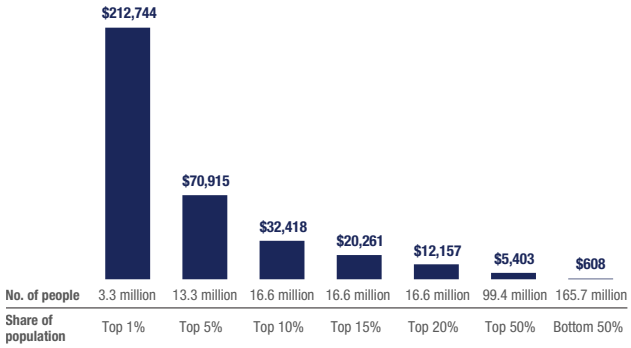
An oft-cited obstacle to inter-state insurance competition is the need to develop robust provider networks.[12] Allowing healthcare expenditures (as separate from health insurance expenditures) to be tax deductible will significantly lessen this constraint.

Part 7 presents reforms that will improve providers' ability to offer innovative models of delivering care for patients. These reforms must eliminate the regulations that unnecessarily restrict providers' actions and introduce new payment models that offer competitive alternatives to the current fee for service model. In addition to these types of reforms, encouraging innovative

delivery models also requires reforms that empower patients over payers – the topic of this analysis.

Just as with health insurance, when patients directly control the healthcare expenditures that do not constitute significant financial risks, they have greater say over their healthcare. The distribution of actual financial expenditures across the patient population demonstrates that this is an achievable goal. Based on data from the Peterson-KFF Health System Tracker,[13] one-half of the population spends around $600 annually on healthcare services. By contrast, the annual expenditures of the top 1 percent of spenders were nearly $213,000.

FIGURE 1
AVERAGE ANNUAL HEALTHCARE EXPENDITURES BY INTENSITY OF HEALTHCARE SPENDING, 2019



Source: Author calculations based on data from CMS and Peterson-KFF Health System Tracker

This expenditure breakdown demonstrates that for most individuals, the majority of their healthcare expenditures in any given year are not insurable events. For these expenditures, there is no justification for enabling payers and insurers to dictate the spending rather than patients. Extending the tax deductibility provided to health insurance expenditures to healthcare expenditures will help shift control over spending to patients. With control, patients will be able to directly influence how their healthcare services are provided. Achieving this goal is simple: allow taxpayers to deduct all personal healthcare expenditures from their AGI in the year that they are incurred.

The combination of making expenditures for health insurance and healthcare services tax deductible encourages the use of high deductible plans that more efficiently cover the financial risks associated with expensive healthcare needs, while empowering individuals to cover the costs that are not actual financial risks.

To help offset the costs associated with possibly expensive future healthcare expenditures, all individuals should have access to tax-free Health Savings Accounts (HSAs). HSAs provide the ability for individuals to deduct contributions to HSAs from their income and then grow this savings tax free, which help them cover the costs associated with future healthcare expenditures should they fall into one of the higher spending categories. Importantly, as an analysis by Fronstin and Roebuck (2019) demonstrated, "as individuals build up balances in HSAs, they use more healthcare services than they otherwise would. In essence, HSA balances may blunt the cost-reducing effect of high-deductible health plans over time."[14]

Put differently, the tax-free benefits offered by HSAs equip patients with the necessary resources so they can cover their deductibles and other out of pocket expenditures should they have to face an insurable healthcare risk.

Individuals controlling their routine medical expenditures, when coupled with innovation from providers (to be discussed in Part 7), lessen the obstacles to inter-state competition created by the need for large provider networks. Since consumers are controlling routine expenditures, they can choose the provider and type of service that best suits their needs. Insurers can focus on establishing a more focused network that responds to true healthcare risks, which is a significant reduction to the obstacles hindering the development of a truly competitive multi-state insurance marketplace.

Beyond the quality improvements, the evidence from high deductible plans demonstrates that reforms that empower patients "bend the healthcare cost curve" by reducing expenditures without reducing quality of care.[15] In assessing these cost reductions, Haviland et. al. (2016),

> estimated spending trends for three years across over 13 million people across the country in an analysis estimating CDHP ["Consumer-Directed" Health Plans] impacts without the threat of individual level selection bias. **We find that health care cost growth among firms offering a CDHP is significantly lower in each of the first three years after offer**. This result suggests that, at least at large employers, the impact of CDHPs persists and is not just a one-time reduction in spending.[16]

A 2012 Rand study confirms these results finding, that "families enrolling in a higher-deductible plan for the first time spent an average of 14 percent less in the first year than similar families in traditional (lower-deductible) health plans."[17] Essentially, consumer-controlled healthcare expenditures incentivize individuals to monitor their healthcare costs. Unsurprisingly, the results are consistent with the incentives.

One issue not yet addressed is the lack of price transparency. This lack of transparency contributes to the market distortions and prevents patients from controlling their healthcare expenditures more efficiently. The Health Policy Consensus Group summarized the benefits from price transparency well stating that

> studies show that when consumers have access to information, they can save money. There is much room for improvement in ensuring that consumers have access to meaningful price information. One state that excels is New Hampshire: People who shopped for care using a New Hampshire price website saved 36 percent. In another example, a Georgia patient was quoted a price of $40,000 for a surgical procedure at a hospital in her home state. She contacted the Surgery Center of Oklahoma, which said it would do it for $3,500. The patient went back to her Georgia hospital asking for a better price, which agreed to do it for $3,500. There are many other examples of the benefits of transparency to employer coverage where transparent prices help patients choose better quality, more affordable care.[18]

Enforcing price transparency requirements across the healthcare system, such as the requirements that hospitals post accurate prices in an understandable format, will promote greater transparency, and meaningfully improve patients' ability to control their healthcare expenditures.

A Patient-Centric Health Insurance System Is Within Reach

The current health insurance system does not serve patients well because the system favors the interests of third-party payers rather than patients. The large tax breaks available to employers but not individuals play a pivotal role in creating and perpetuating this problem. Extending the same tax benefits to individuals eliminates this relative cost distortion.

With the price of insurance no longer distorted by tax considerations, patients can gain control over their insurance policies. When coupled with tax deductibility for healthcare expenditures and the availability to use HSAs to save for future healthcare expenditures, these reforms would put patients in control over their own healthcare expenditures. Importantly, the reforms would allow health insurance to become effective insurance, which will lessen the problems associated with excessive healthcare financial risks.

Coupling a more efficient health insurance market with the reforms discussed in the remainder of the *Coverage Denied* series compounds these benefits. Part 6 begins this analysis with an examination of the reforms necessary to improve the pharmaceutical market.

Endnotes

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