

**2006 National Policy Forum – Day 1
Prospects and Implications of
Tax Policy for the Health Care Industry
March 7, 2006**

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Dan Leonard: My name is Dan Leonard. I'm the executive vice president of advocacy and professional services at AHIP. Thank you so much for coming to our conference. We hope you're enjoying yourselves and learning a lot. I know we put you through a grinding day, starting at eight o'clock this morning and going on through events into the early evening, but there's a lot of ground to be covered, so we're glad you could all be here.

We've got an excellent session lined up for you right now, and it is my pleasure to introduce our speaker, Dr. Jonathan Gruber. And he will address the topic Prospects and Implications of Tax Policy for the Health Care Industry. Dr. Gruber is professor of economics at the Massachusetts Institute of Technology and co-editor of the *Journal of Health Economics*, and associate editor of the *Journal of Public Economics*. He has taught at MIT since 1992. He's also the director of the program on Children at the National Bureau of Economic Research, where his is a research associate.

Dr. Gruber received his bachelor's in economics from MIT, his Ph.D. from Harvard. He also received the Alfred P. Sloan Foundation research fellowship. He was also one of 15 scientists nationwide to receive the Presidential Faculty Fellow Award from the National Science Foundation in 1995. During '97 and '98, Dr. Gruber was on leave as deputy assistant

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secretary for economic policy at the Treasury Department, and we just found out he lived in Washington during that time period, and we're glad to have him back, at least for a day or so.

Dr. Gruber's research focuses on the areas of public finance and health economics. Recent areas of particular interest include the economics of employer-provided health insurance, something that's of interest to all of us, the efficiency of our current system in delivering health care to the indigent, the effects of the social security program on retirement behavior, and the economics of smoking.

So with that, I will introduce and welcome to the podium Dr. Jonathan Gruber. [Applause]

Jonathan Gruber, Ph.D.: Thank you. Thanks for that nice introduction. Today I want to talk some about tax policy for health insurance, and I hope my talk will be a little bit controversial. I'm going to try to introduce some of the thinking that's been going on in academic circles about how we might use the tax code to promote or change health insurance markets.

So let me start with, I hope, my somewhat controversial first line, which is: I think that we can view America as the land of under-insurance and over-insurance. What do I mean by that? I mean we have almost 46 million Americans with no health insurance, and yet most of the rest of us have too much

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health insurance.

What should health insurance look like from an economist's perspective? Well, health insurance from an economist's perspective should have three features: first of all, it should protect against financial catastrophe; second of all, it should encourage appropriate medical care; and third, it should discourage inappropriate medical care. And the evidence is clear: such an insurance structure would lead to lower health costs relative to what we have today without sacrificing health care, without sacrificing health. This evidence comes from the well-known Rand Health Insurance Experiment, a study now 30 years old and yet still the gold standard for thinking about health insurance design.

What did the Rand Health Insurance Experiment do? In the mid-70s, back when we were able to do these things to people, it randomized people in different health insurance plans. Some people got free health care; some people had plans where they had to pay essentially all the health care out of pocket, although everybody had an out-of-pocket limit of \$1,000. What did they find? They found that people in plans with a 95 percent co-insurance rate—that is, where they paid virtually all the costs of health care—used about one third less health care than people for whom health care was free. So there's a very strong effect of price on health care use; that is, people actually care about what it costs to go to the

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doctor. They go to the doctor less if you make them pay.

But at the same effect, the Rand study found no adverse effect on health, the most incredibly striking find; that on average, people went to the doctor a third less, but were no less healthy. And this is from a very detailed health battery. There were some sub-populations in which they found some adverse health effects, and I'll come back to that. But overall, there was a large reduction of health care utilization relative to full health insurance, with no sacrifice in health.

Now, relative to what Rand found, what is health insurance look like today? Well, it doesn't look like those studies would suggest it should. First of all, health often has capped annual lifetime benefits, which goes against the fundamental principle that you should be protecting against catastrophe. Second of all, there's typically very little patient co-payment. That's changing now, especially prescription drugs. But still, for physician visits and many things, there's very little patient co-payment for any level of care. And there's no distinction in co-payments by the effectiveness of care. It's \$10 a visit no matter what you're going for.

Now, why is it? Why do we have this system where we could actually save a lot of money by having people pay when they go to the doctor and use medical care? They wouldn't be in any worse health, and yet we don't take advantage of that.

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Why is that? Why are we the land of over-insurance in the U.S.? There are two reasons for that. The first, and I like to use the word taxes finally, is the tax subsidy to employer-provided health insurance. Employers pay you in cash wages, and when they do, you pay taxes. So when MIT pays me a dollar, as I painfully know this time of year, I'm only going to take home about 55 cents after I've paid all my taxes. I'll take home after I pay my payroll tax, my income tax, my Massachusetts state income tax, I'll take home about 55 cents of that dollar they've paid me. But if MIT gives me a dollar of health insurance, I get the whole dollar. I'm not taxed on that. So what that means is, you pay nothing in taxes your employer pays you in health insurance, but you pay a lot in taxes if you're high income and your employer pays you in wages. This tax subsidy amounts to about \$140 billion a year in lost tax revenues to the government. What that means is, if we treated employer health insurance expenditures the way we treat wages, we would raise \$140 billion this year, rising obviously over time as health care costs rise. So that's one issue with this.

But the other big issue is that this subsidy promotes excessively generous insurance. Think about me facing the choice at MIT. Let's say MIT comes to me and offers a deal. They say, "Look, we can give you generous insurance at somewhat lower wages, or less generous insurance and higher wages."

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Well, when I get the higher wages, I'm going to have to pay almost half of that to the government. But if I get the more generous health insurance, I pay nothing to the government. So I'm going to say, "Hey, give me the lower wages and the more generous health insurance. That's a much better tax deal for me." So part of the reason why people have such generous health insurance is we've promoted them to do so by letting them avoid taxes the more generous their health insurance is. The more generous your health insurance is relative to wages, the less you pay in taxes. So that's one reason why health insurance is so generous in the US, the employer tax subsidy.

But there's another reason, too, which is harder to quantify, but I've come to believe is more important, which is just the psychology of the health insurance market. And I feel a bit ridiculous lecturing this group on how the health insurance market works and how people think about health insurance. But I think you'll agree that individuals don't think about health insurance the way I laid out. The way individuals think about health insurance is medical pre-payment. They have the notion that, "I pay my monthly premium, and in return, my health care is free, or basically free." And that's the way they think insurance to work. People don't want a policy where they're going to pay a lot when they go to the doctor. That, to them, is not insurance. They view insurance in this medical pre-payment model, where they pay once a month

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and they can forget about it the rest of the month.

But that, to an economist, is not the way insurance should be structured. The way insurance should be structured is you should pay something along the way so that you use care cost consciously, so that you don't go to the doctor just when you have the sniffles; so you stop and say, "Wait a second. Is it really worth it to go to the doctor?" And what the Rand Health Insurance Experiment shows is, if we make people that cost conscious, they will use less care, but they won't be in any worse health.

So how do we get there? That's what I'd like to focus on today. How do we get to this world where people are using health care more cost consciously? Well, there are several tax policy solutions to getting there. The first way to do it is to reform the employer tax subsidy, this \$140 billion we spend every year by not taxing you on your employer's health insurance spending. We could remove this completely. We could basically say, "Look, starting tomorrow, whatever MIT pays me in health insurance is included in my taxable wages." So MIT probably spends about eight grand a year on my health insurance. Suddenly, I'd get taxed at \$8000 more a year. We'd include that in my taxable wages. Now, this would have significant benefits. It would raise about \$140 billion a year for the government. It would reduce my incentive to have excessively generous insurance. Now I'm going to say, "Wait a

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second. I'd rather have wages than have that excessively generous vision coverage package," or whatever they're spending so much money on at MIT. "I'd rather have wages, because there's no real tax disadvantage to do so." And the other thing is, you would basically reduce the fact that we rely so much on employers for health insurance, because individuals would not get health insurance other places, and they might be less unwilling to leave their job because they're afraid of losing health insurance, or this so-called job-lock problem.

However, removing the employer subsidy has enormous costs as well, which is, it could lead to a dramatically restriction in employer-provided health insurance coverage. I've estimated that if we got rid of this entire subsidy, the number of persons covered by employer-provided insurance could fall by as many as 20 million people, or almost half as many people as are uninsured today. And these people will be cast from a market that works, which is the employer market, to a market that largely doesn't work for many people, which is the non-group market, a market where it might be hard to find health insurance if they're sick, or health insurance can be very expensive. So you can't really get rid of the employer tax subsidy in a vacuum. It just doesn't make sense to destroy this mechanism, which now works very well for most people, or destroy a lot of it, and throw people out there with no other solution.

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The only time it makes sense to get rid of this would be in the context of a larger system reform. We offer people a better non-employer option to go to; some pooling mechanism, some way that they can get health insurance in an effective way, even if it's not from their employer. If we're not going to do that, it's just going to be too disruptive to get rid of this employer tax exclusion.

However, there's another option, which is to cap this exclusion. Let me explain what I mean by this. What's nice here is actually there's a great example that was proposed by the president's own tax reform commission. The president convened a tax reform commission, which had a number of experts, including some academic economists on it. And they came up with a proposal to reform the tax system in a fundamental way.

One element of that proposal was to actually cap this employer exclusion. What does that mean? What they proposed was: until your employer spends \$11,500 on your family policy, nothing changes from today. But every dollar above \$11,500— which is sort of the cost of a typical good health insurance plan—every dollar above that, you get taxed on. So if my employer wants to buy me the Cadillac coverage that costs \$13,000 for a family, that's all well and good, but I'm going to pay taxes on the last \$1500. What is that going to do? That's going to mean my employer's going to have a disincentive

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to buying that Cadillac plan. They're going to say, "Wait a second. If I buy that excessively generous plan, my employee is going to pay more in taxes." So that's going to reduce this incentive to excessively generous health insurance, and promote people to use more cost-effective health insurance plans.

So the basic idea here is, if we get rid of the entire \$140 billion tax subsidy, that could be very disruptive to the employer market, could lower employer-provided health insurance a lot. By capping it, the employer market will stay vibrant but will reduce the incentive for this excessively generous insurance that exists by tax subsidizing every single dollar you spend on health insurance. So that's one direction we could go, is we could say, "Look, we'll cap that."

However, public policy debates lately have moved in a very different direction that I don't find nearly as promising, that I want to talk about. This is really where the current policy context is, which is the alternative approach. The alternative approach is to say, "Look, yes, there's this tax break to employer-provided health insurance. But you know what? Let's counteract that by offering a tax break for out-of-pocket medical spending." So right now, the problem is that if I get really generous health insurance, I don't pay taxes on that. But if I get paid in wages and go to the doctor and pay on my own, then I'm going to get taxed on that. So a recent proposal that's gotten a lot of attention from Cogan, Hubbard

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and Kessler is to say, "Look, out-of-pocket spending would also be tax deductible." So now the basic idea is I can go ahead and get a cost-effective plan. Before, if my employer said, "I'll tell you what. I'll pay you \$1,000 more and you have \$1,000 deductible," I'd say, "Forget it. I don't want that." But if now my employer says, "I'll pay you \$1,000 more, and you get \$1,000 deductible, and you get to write that off on your taxes," then it might be more attractive. And that's the idea of this proposal.

The problems with this approach, however, are numerous. First of all, this is very expensive. This proposal alone will cost over ten billion dollars a year in lost government revenues. And it's also very regressive. This gives the biggest tax break for wealthy individuals. Any time you have a deduction from taxable income, the higher your tax rate is, the more it's worth to you. So a deduction to someone in the ten percent tax bracket is only worth ten cents on the dollar. A deduction to someone in the 35 percent tax bracket is worth 35 cents on the dollar. So one problem with this is the tax break is most valuable for wealthy people.

But the more important problem is this essentially just entrenches our existing flawed system. This is sort of a two-wrongs-make-a-right approach. We've got this enormous \$140 billion monster that's causing people to get insurance that's too generous, so they want to introduce a new \$10 billion mini-

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monster to try to offset it. But that's just going to entrench the existing system. It's not going to actually move us in the right direction. Moreover, this could potentially erode employer coverage, because now, since people have their out-of-pocket costs covered, they can just go uninsured and just pay for it themselves. But more important than this is once again this psychology of the market. The notion here is the sort of "If you build it, they will come," *Field of Dreams* strategy; the notion that, gee, if we just tax subsidize people's out-of-pocket spending, they'll suddenly get this more cost-effective health insurance. But there's no evidence that that will really happen.

That has led to an alternative approach, which is the sort of hot topic of today, which is the HSA solution. So what are HSAs, or Health Savings Accounts? Most of you probably know what they are, so let me just sort of run through a few of the particulars. HSAs are plans that are high deductible health insurance plans tied to a savings vehicle. So the way it works is, you have to have a plan with a deductible of at least \$1,050 for individuals, or \$2,100 for families. Then tied to that is a savings account into which you can put money on a tax-free basis, that you can then take out on a tax-free basis to pay for your health costs. So think about it this way: some of you are used to your 401Ks at work, or IRAs. The way those work is you put money in tax-free, but then when you

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take it out when you retire, you're taxed on it. HSAs are much more generous than that. With HSAs, you put money in tax-free, and then when you take it out, as long as you spend the money on medical care, it's tax-free again. So it permanently escapes taxation. It's not delayed taxation, like with a 401K or an IRA. It's permanently avoided taxation. You're never taxed on that money as long as you spend it on medical care. So this is much more generous than any other tax subsidy in existence. There are some estimates that suggest this is about 50 percent more generous than, say, a dollar in a 401K. It's about a 50 percent bigger tax break.

So, as I said, here you can take the money out tax free for qualified medical expenditures. If you take it out for non-medical spending, there's a penalty before age 65. After age 65, it becomes like an IRA, or a 401K. You can take it out and you're just taxed on it. So essentially, after 65 this is just like a retirement savings vehicle that we have through our workplaces, typically, except if used for medical care, it's totally tax-free.

Now, why HSAs? The advantages are, they directly address the psychology of the market. Here's the way I view HSAs: they're essentially saying, "Look, people don't want high deductible plans. It is not attractive to people. It's not the way people think about health insurance." The idea of the HSA is, "Let's bribe people to have this structure of plan."

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I'll tell you what. If you have this high-deductible plan, we'll attach to it this very valuable savings account." And in principle, you can see the appeal of that. It's sort of saying, "Look, we've got to drag people into this way of thinking about health care. We'll drag them in by attaching this tax subsidy." So it's sort of a bribe to people to buy the kind of health insurance they wouldn't want on their own. I think that's a sensible way to think about why HSAs are structured the way they are.

However, this advantage is offset by a number of disadvantages. And the most important of these disadvantages is that deductibles in plans are not the best way to promote cost-effective health care use. The way I like to think about this is the following: deductibles are, in general, either too high or too low. What I mean by that is, for a very poor person, a deductible is too high. If a person with \$20,000 of income is going to have a \$2,000 deductible, they are going to avoid care that's not only ineffective but may be effective as well. They're just really going to avoid the doctor, because it's just too burdensome for them to try to pay \$2,000 a year on top of their health insurance premiums to get health care. So that's going to be too high. For a rich guy, \$2,000 is too low. Look, I've spent more than \$2,000 on my family's health care every year for the past seven or eight years. There's no way this year I'm not going to spend it. It's February; I know

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already, by June I'm going to be well beyond \$2,000. So for me, this does nothing to affect my medical spending. I view it as \$2,000 I'm just going to have to pay. But is it going to affect my decision to go to the doctor? No, because I know I'm going to pay it anyway. So for me effectively, each doctor's visit is free. Right? Because I know that by the end of the year, I will have used up that deductible. So I'm in the range where the care is free. So if I have a deductible plan, it's not going to affect my utilization.

So the deductible is either too high or too low. Now, of course, there's a middle group of people for which it can actually affect their decisions in a positive way. But you're really with a deductible trying to sort of thread the needle. You're trying to say, "Okay, we want it low enough so the poor aren't bankrupted, but we need it high enough so high expense people actually pay attention to it." And that's a very tough thing to do with one deductible level. That's one problem with the HSA.

The second problem with the HSA is that the tax break component is very expensive and once again very regressive. Basically, this linkage of a tax-preferred savings vehicle with a health insurance plan is really unnecessary and very, very expensive. In fact, for a high-income individual, there's no reason this should have anything to do with health at all. In fact, many investment managers and banks are suggesting to

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their clients that they open an HSA and never touch the balance, but rather pay for their health care out of a taxable account. Why is that? Because this is the best retirement savings in the world. This is 50 percent better than a 401K. So if you want to save for your retirement, there's no better way to do it than an HSA. You should save for your retirement in your HSA and pay for your health care out of a taxable account. And then, when you retire, if you spend it on health care, it's completely tax-free. If you spend it on a car, you're no worse off than a 401K. So it's a much, much better retirement savings vehicle.

So in fact what happens is that basically people are going to use these things, not for health reasons, but just as retirement savings vehicles. In fact, this is something that was driven home for me by the recent proposal in the president's budget. The way HSAs work now is, if you want to contribute more to an HSA, you have to have a bigger deductible. So if I want to contribute \$5,000 to my HSA, I have to have a plan with a \$5,000 deductible. The recent budget proposal would actually break that link. It would say, "As long as your deductible is above \$2,000 a family, you can contribute anything to your HSA account, up to \$10,000." Well that, in some sense, lays clear that this is not about health policy anymore. This is about savings. This is about having a savings incentive for people, and the health policy is sort of

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an attractive cover for having a savings vehicle for people.

Now, once again, I'm being polemic here in extreme, because I think people have been polemic in extreme on the other side, so I'm trying to sort of lay it out. But the key point here is that the notion of this bribe, the notion that I'm going to bribe you to have more cost-effective health insurance, while attractive in principle, in practice is basically leading us to just set up a new, very expensive, very regressive system for retirement savings, which is what this really amounts to.

Now, as I said, the recent budget proposal of the president would actually propose additional subsidies to HSAs. And once again, I don't meant to pick on the president here in particular; this is something that is popular in many circles. I'm just using it as a particular example of how people want to expand HSAs. You could point to 12 different proposals out there. I'm just picking this one because I had it in front of me, I had the president's budget in front of me, so it was easy to take a look at and think about. So what the president proposes is making HSA plans tax deductible and also adding an extra tax credit for contributions to HSA plans. So now not only would your contributions to your HSA plan be tax-deductible, you'd also get a 15.3 percent credit for every dollar that you contribute to your HSA account. I estimate that these proposals will cost about \$12 billion a year, and

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that's not very different from what the president's own Treasury Department gets. This is not an outrageous amount of money; it's pretty expensive. But what I find that's more striking is that these proposals don't do anything to lower the number of uninsured. If anything, I find they increase the number of uninsured.

How could that be? How can you subsidize health insurance and raise the number of uninsured? Well, the way you can do that is because now—remember, why do employers offer health insurance? Largely because there's this big tax break for them to do so. This is leveling the playing field. It's offering a huge tax break to get insurance outside of the employer sector. So if I'm an auto body shop, and the only reason I offer health insurance is because there's this big tax subsidy to do so, now I say, "You know what, guys? You can get an equally big tax subsidy outside the employer system. I'm dropping my coverage. I'm not going to do this anymore. I didn't want to be in this business in the first place." Is this going to affect MIT? No. Is this going to affect GM? No. But it will affect the auto body shop. It will affect small employers. They're going to say, "I don't want to be in this business anymore. You can get the same tax break now outside of the employer setting. I'm going to drop health insurance. You go get it on your own."

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Well, what this means is that some employer, a small fraction, but some employers will drop health insurance coverage. I estimate about five percent of employers will drop health insurance coverage. But that's about nine million people who will lose employer-provided health insurance coverage, because now the playing field has been leveled, in essence. Okay? So what does that mean? That means that I estimate that on net, some uninsured people find HSAs attractive and take them, but other people become uninsured because employers drop their health insurance. And you end up raising the number of uninsured by about 600,000 people. In this analysis, if you look at the Center for Budget and Policy priorities, this analysis is on their website, and I'm happy to send it to people if they want. But basically, this is saying that expanding HSAs is not going to increase health insurance coverage. If anything, I estimate that it's going to lower health insurance coverage. It's going to introduce a very expensive tax break for wealthy people. And I don't see any evidence that it's going to do an enormous amount to lower health care spending, because deductibles are a very crude tool for lowering health care spending.

Can this guy be positive? Yes, I can. Look, once again, I wanted to come here and rattle some cages and try to get people thinking about the downside of something you're maybe only hearing the upside of. But at the same time, I want

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to recognize what's good about HSAs, and what's good about this debate, which goes back to the start of my talk. For too long, we've ignored the role of consumer cost consciousness in the health care sector. For too long, we've just assumed the consumer is a passive consumer, will only go to the doctor when they're sick, and so we should just go ahead and cover all their medical expenses. That's not the right way to think about health care. We need to promote consumer cost sensitivity. We need to promote rational use of health care.

But there are better ways to do it, and I've laid out one here, something I call Cost-Effective Health Insurance. This would have three central features. First of all, there would be very high coinsurance rates; coinsurance rates, not deductibles. What's the difference? Let me explain the difference. Let's compare a \$1,000 deductible to a plan with a 33 percent coinsurance and a \$1,000 out-of-pocket max. Now, consider yourself going to the doctor. With a \$1,000 deductible, you're going to pay attention to that cost until you hit \$1,000. Then you're going to ignore it. With a 33 percent coinsurance, you're going to pay attention until that cost hits \$3,000, because only then do you hit your out-of-pocket max. That is, by using a coinsurance, we stretch out the range over which you're price-sensitive, and thereby make you price-sensitive for a much larger range of health insurance purchases. So you don't have this problem with trying to hit

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the target. You're not trying to thread the needle anymore. You're allowing people to be cost-sensitive over a much larger range. Now suddenly, if this out-of-pocket max is \$2,000, then I know that unless I'm going to spend more than \$6,000 this year, I do have to pay attention to my coinsurance. Now, suddenly you've got my attention. Okay? So that's one feature.

The second feature—this is critical—is an income-related out-of-pocket limit. I've chosen what people consider a very high number here; say, seven percent of income. What does this mean? This means that you would pay 30 percent every time you went to the doctor, but only until you'd spend seven percent of your income. Why is this important? This is important because of the other problem with deductibles: they don't work for the lowest income populations. And this is particularly important because this is where I'm considered by the left to be very right wing; which is, I believe that people should pay when they go to the doctor. And the criticism, and the thing that runs into politically, the difficulty with trying to promote cost conscious consumers is people say, "The poor people won't get care. The poor people won't go to the doctor if you make them pay." And the answer is to have poor people pay less than rich people when they go to the doctor. If poor people can't afford to pay a lot for health care, let's limit their exposure, to make sure they don't stop getting

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health care like they will with a \$2,000 deductible. Let's limit their exposure in an income-related way, so people are cost conscious, but they're cost conscious in a way that nobody's bankrupted. Remember the first principle of insurance: no one should be bankrupted by health care costs. That's what an income-related limit does.

Then finally, and most tricky, because I don't have a great answer for this, you would then want to organize it in theory so you actually target it not just to income but to service. For example, mammograms would not be subject to a coinsurance, one mammogram a year; or one well child visit, immunizations. You basically want to target it so that it was actually targeted to more effective health care use. Now, the evidence is clear that a plan like this would promote healthy behaviors, reduce medical costs and protect low-income groups.

And as I said, you could also refine it even further. And this is not in the presentations, but let me refer to a recent study I'm doing right now with a couple of co-authors. We looked at the experience of CalPERS, California's Public Employee Retirement System. CalPERS, when facing a fiscal crisis in 2001, raised significantly the co-payments that people faced in those health insurance plans. And in particular, we looked at elderly people, where before doctors' visits were free, and they raised it to \$10 per visit. Prescription drugs used to have a \$5/\$15 two-tier structure,

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and they raised it to a \$5/\$25/\$40. So they had significant increase in co-payments for both doctors' visits and prescription drugs.

What happened? Enormous reductions in utilization; about a 20 percent reduction in use of both physician visits and prescriptions. Think about that. Ten dollars. These are public employment retirees; these are not poor people. Ten dollars caused a 20 percent reduction in physician visits and a 20 percent reduction in prescription utilizations. And yet, as far as we can tell, there was no adverse impact on people. Most importantly, there was no change in hospitalizations. The criticism we get from the left will be, "Gee, if you do this, poor people won't get care. They'll end up in the hospital." Not true. No increase in hospitalizations.

But, that was on average. We focused in particular, then, on chronically ill populations, those with diabetes, hypertension, arthritis, depression. For those chronically ill populations, we found that there was a pretty comparable reduction in care, about 20 percent, but that hospital utilization went up. And in fact, hospital utilization went up so much that it essentially offset almost all of the savings from using less of a doctor and less prescription drugs.

So what's the lesson here? The lesson is, on average, we can make people pay more. They'd use a lot less care and be in no worse health, which is what Rand found 30 years ago.

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Okay? It's exactly mimicking 30 years later that finding. But, that for certain sub-populations, you want to target, because for those sub-populations, there can be adverse effects on health, of them reducing their utilization; and that the cost-effective system would be something that would target not just on income, but would target the most effective kinds of care. So one of the advantages is it's progressive, not regressive. It recognized that higher income families can pay more for health care and should pay more. There are larger net insurance gains, because it's targeted to low-income families. And it really changes the psychology of the market by promoting the right kind of health insurance.

How would you do this? Well, that's why it's good to be an academic and not a politician. I don't have to figure that out. But basically you could have the federal government offer such a plan, or contract with private insurers to offer such a plan. A government offer could sort of kick start the market, and then you could hope the market would develop, with people demanding these kinds of plans. You could do it through an existing mechanism, like the Federal Employee Health Benefits pool, or through new pooling mechanisms.

Let me here also put in a bit of a plug for what we're doing in Massachusetts. I don't know if people have followed, but we're in the midst of a very heated debate over pretty fundamental health reform in Massachusetts right now. Even as

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we speak, House and Senate negotiators are locked in a room trying to hammer out the details. And the fundamental core of the plan is a new central purchasing mechanism, where everyone can get health insurance in a group way, with large subsidies for low-income individuals. But those subsidies would be tied to a more rational, sort of more cost-sensitive kind of health insurance; or at least that's what they're debating right now. And that could be a way to actually get people to think more sensibly about the way to structure health insurance.

Financing, well, that's always the tough part, right? We can raise some money if we limit the employer tax subsidy. Or you could remove the employer tax subsidy and replace it with this new central system, where these more rational health insurance plans are covered. But we're not policy-makers. That's not really what we have to worry about. We'll leave that for the people elsewhere in town.

So let me conclude. Several points: first of all, tax policy promotes over-insurance in America. There are people who have health insurance that's by and large too generous, and that's partly because we're buying it with 60- or 70-cent dollars. Okay. Point two: many proposals to rationalize tax policy by introducing a two-wrongs-make-a-right strategy, by saying, "Gee, we have this existing subsidy. Let's add a new subsidy to try to offset it." And that's simply wrong headed. Okay? And they don't do much to promote cost-effective

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insurance. There are structures, and I've tried to lay out one, which is not the only one, by any means. People in this room are much more qualified than I to think about these issues. It's not the only one, by any means, but an alternative structure to go much further towards rationalizing the way people get health insurance.

But then let me make one final point, and let me once again conclude on a negative note. Okay? If health economists have learned anything in the last decade and a half, we've learned that what drives health care spending is better health care. What drives better spending is the fact that we're getting much better medical care. And this is not going to do a lot to solve that problem. This kind of consumer cost-consciousness is not going to do a lot to solve that problem. People are still going to get cutting edge, really expensive, really good health care. And that's probably a good thing. By and large, I think economists think the dollars we spend on health care are worth it in terms of the improved health we're getting.

What I'm talking about here is working on the margins, to make consumers more cost conscious. Maybe, if this could lower health care costs by five percent, ten percent, I'd be delighted. People who advocate consumer cost consciousness as solving our health care cost crisis are just wrong. The only way you're really going to bring costs in line is to actually

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start rationing care, and to actually limit the extent to which people are getting very expensive, great new sources of care. I, for one, wouldn't advocate that, but I think we have to be realistic about what we can and can't accomplish with approaches like this.

So, anyway, thank you. [Applause]

Dan Leonard: Well, that was a real provocative presentation, and I'm glad you presented it in the way you did to get us thinking about alternatives. This is the portion of the program where we take questions from the audience, so we have some microphones walking around the room. Who's going to start us off? Right here in the front.

Chris Ramsey: Good afternoon. I'm Chris Ramsey. I'm with Blue Cross/Blue Shield of Tennessee. Dr. Gruber, first of all, I want to thank you for your enlightening insights regarding health care. A couple of questions, just to make sure I understood: on your proposal to the cost-effective health insurance, how did you propose to actually address the pharmaceutical side of it? I know it mainly dealt with outpatient services, but in most plans, the drug coverage is accounting for about 20 to 25 percent of the health care dollar. So what would be your proposal as far as covering drugs? Would it be a percent co-pay, similar to the outpatient services?

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Jonathan Gruber, Ph.D.: You know, I would treat it like outpatient. I think there's actually a case to be made for having even higher co-pays on drugs than for other outpatient services, as we do in most plans today. I think there's an interesting question that you are all better qualified than me to decide, which is: is the right thing a dollar co-pay or a percent coinsurance? Percent coinsurance is sort of more economically rational, but maybe it's too hard to administer. I don't know. But I would certainly have at least as high cost sharing for drugs as for outpatient; probably a big higher.

Chris Ramsey: One last question dealing with the retiree drug subsidy, and of course I think CMS encouraged employers to continue to cover their retirees. Do you foresee next year that a lot of employers are going to actually drop their retirees from actually having their coverage through them and require them to sign up for Medicare Part D? What are your thoughts on the retiree drug subsidy?

Jonathan Gruber, Ph.D.: Well, it's important to recognize that economists are a lot better looking backwards than looking forward. But in terms of looking forward, I think that's certainly the direction they're going to go. What's hard to figure out is if the subsidies CMS has put in place are large enough to really stem that. But I think it's certainly the direction it's going to go. I think a lot of it will have

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to do with how the experience goes this year. Right now, it's not a very sanguine prospect, to be throwing your people into that situation. If things calm down, like I'm sure Mark McClellan hopes they will soon, then that might be more attractive. If things remain a bit chaotic, employers may not be ready to cast their employees into that.

Dan Leonard: Question over here.

Paul McBride: Yes. I'm Paul McBride with WellPoint. In the mid-90s, we had, of course, the MSAs. And I think everybody remembers there were limits placed on MSAs. There was concern that the marketplace would sort of stampede into MSAs. That, of course, didn't occur. Now we have HSAs receiving much more popularity. Can you maybe explain what the differing factors are that have driven the marketplace differently?

Jonathan Gruber, Ph.D.: Sure. I think it really comes down to this bribing principle. Basically, MSAs weren't popular because people want generous insurance. They want first dollar coverage. That's what Americans want. MSAs weren't offering that. So they took the next step and said, "We'll pay you to have a high-deductible plan." And when you pay people to do things, they do things. So basically I think the growth of HSAs relative to MSAs is just tied to the fact that there's a bribe tied to them.

Now, that said, I for one, once again to take the

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horrible step of projecting the future, I don't see HSAs taking over the world like many people do. I think Americans, even with the bribe, by and large still have this psychology problem. That's just not how they think about health insurance. They don't want to pay when they go to the doctor. And so I think we need perhaps to be even more aggressive in addressing that psychology problem in the market. But nonetheless, I think it's just dollars that explain the difference.

Dan Leonard: We have a question in the back.

Male Speaker: While the employer tax subsidy clearly has focused the discussion on the federal tax system, do the states play any meaningful role in the debate over tax policies at the state level?

Jonathan Gruber, Ph.D.: The states don't play a very meaningful role on the tax policy side. They're just too small a share of the tax pie, and their rates are so small. In principle, Massachusetts could start taxing my MIT's health insurance contributions, but first of all they'd have to set up a whole new mechanism to do that because it wouldn't be on my W2 now, so they'd have to set up a mechanism to do that. And that would only be five percent of my total 45 percent tax burden, so it wouldn't really have a huge effect. So I think, really, it's a federal tax policy issue.

Grace Tingwell: Hello. Grace Tingwell, Point. I

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think that from your presentation, it would seem to me that some kind of income determinant or income threshold would be some level of protection against the regressive tax syndrome. But it would also occur to me that it could serve to drive up maybe income verification and/or claims adjudication, therefore administrative costs. Were there any projections as to how much this type of a model would impact administrative costs, and how would that, therefore, impact the net efficiencies?

Jonathan Gruber, Ph.D.: Once again, this is why it's lovely to live in the ivory tower. [Laughter] I would love to hear from you all on that. Obviously, economists tend to believe that if something was really good, it already would be sold. The fact that you don't see these types of policies clearly gives me a sense that there's something in the way. It's probably administrative costs; they're probably quite high. And that is a disadvantage to this approach. I'll readily admit that. I hope that as we move to better IT and better systems, those problems can be solved. But clearly this is much more administratively burdensome than just having deductible.

Dan Leonard: Up front? Stephanie?

Carlton Dennis: Carlton Dennis, Independence Blue Cross in Philadelphia. I like your consumer effective health insurance. Have you had an opportunity to share that with the CMS, or do you deal in that form?

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Jonathan Gruber, Ph.D.: I don't really know what the context would be. It doesn't really make sense for Medicaid, because they're so low income. In some sense, the truth is that CHIP, the CHIP program for kids, is not actually that different, in the sense that once families are above 150 percent of poverty, states are allowed to implement premiums and co-payments up to five percent of income, which is sort of a shortened version of exactly what I'm talking about. In some sense, a policy like this, the closest thing to this does exist in the government today. Another interesting to see is under the recent bill that was passed this year, states will have a lot more leeway to putting co-payments for their Medicaid populations. And I hope that CMS will promote them to think about these kinds of plans. But I've not talked to CMS about it.

Carlton Dennis: Just a follow-up question, a different question on rationing. You mentioned that, and earlier speakers talked about universal health care. What's your view on that? I know at the end of your talk you mentioned that we probably would have to go to some type of rationing.

Jonathan Gruber, Ph.D.: There are two questions there. Let me start with the second one, which is: do we need to do rationing? I don't actually believe we do. Basically, I think what health economists have really concluded is two things which at first seem contradictory but in fact aren't, which is:

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first of all—and this conclusion is most associated with the work of my colleague David Cutler at Harvard—first of all, over time, our health care dollars have been effectively spent on average. That is, no one wants to have 1950s health care at 1950s prices. The health care we're buying today is much better than it used to be. And if you use typical values of quality of life years and things like that, on net, we're better off now than we were, even though we're spending more. At the same time, I could, today, look back and say, "Of the 15 percent of GDP we spend on health care, I bet we could knock five percent of it out and people would be no less healthy."

Now, how are those two things consistent? They're consistent because it's easy to look backwards. It's hard to look forward. So it's consistent because looking backwards, we can say, "Gee, a lot of this stuff we do is wasteful. Let's get rid of it." But we don't know, of the new innovations, which are going to be wasteful and which aren't. Rationing, putting a cap on, is just as likely to cut out the positive innovations as it is the negative innovations. And that's the problem. In other words, if we rationed in 1950 and said, "Health care should not be more than five percent of GDP," we would be much worse off as a country today. Likewise, if we today said, "Health care should not be more than 15 percent of GDP," I predict we'd be much worse off as a country in 2100. I think we need to find another solution, other ways to try to

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get at this than rationing because I think rationing is just too blunt an instrument, given the overall positive advances.

Now, that said, universal national health insurance, there are two components to that. One is universal coverage. Universal coverage can be done making all of you happy. You can have universal coverage for the private health insurance industry. That's what we're proposing in Massachusetts. There would be a central pool through which private insurers would offer policies. But, we would mandate that everyone in the state be covered. Okay? So that's universal coverage with the private insurance sector.

National health insurance means wiping you all out. I just personally don't see that as even worth discussing, for political reasons. As well, I think there are some real economic arguments. At least I think there are economic cases to be made on either side. But the truth is, I just don't think, politically, we're just ever going to be in a place where we can seriously consider national health insurance, Canadian-style health insurance. I just don't think it's worth our brain cells worrying about it.

Dan Leonard: Thank you for that, by the way.

Jonathan Gruber, Ph.D.: Well, I've made enough enemies today.

Dan Leonard: Yeah, right.

Jonathan Gruber, Ph.D.: I figured I'd make a few

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friends. [Laughter]

Dan Leonard: Redeeming yourself.

Amy Haley: I'm Amy Haley with Group Health from Seattle. I'm curious. These proposals that we've been discussing for the last day and probably into tomorrow are all dealing with the demand side, sort of the consumer demand for health care. I'm wondering what smart economists like you are thinking about in terms of the supply side, and the fact that we've got an undersupply of primary care physicians and an oversupply of specialists. And we know that that creates all sorts of disincentives and mis-utilized scarce resources. So I'm wondering if you've thought about tax policies or anything to deal with the supply side of the issue.

Jonathan Gruber, Ph.D.: You know, there's a fundamental tradeoff here, which you can already see. The question about administering my CEHI plan brought it up. There's a fundamental difficulty between doing what's right and excessively meddling. In an idea world, Tom Philipson could run the health sector, and he would know exactly which doctors to subsidize and which not, and we'd all get it exactly right. But unfortunately, Tom doesn't run the health sector. A bunch of politicians do. And where they put their tax subsidies may be where they're most effective, or they may be where their constituents are. And in some sense, what's tricky is the more of that you do—there's a tradeoff—the more opportunities for

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meddling, the more unproductive meddling can happen.

Now, what I'd like to think is we move to a more rational system where I actually bore the cost of going to that specialist because I feel like I just want to check out how my elbow's feeling. Then maybe, if that was going to cost me \$100, \$150, maybe I wouldn't go to that specialist, and maybe there would be lower returns to being a specialist and higher returns to being a GP; that maybe if you make consumers use health care more rationally, that could actually change incentives in the system.

Will that be enough? I don't think so. But that's at least a step in the right direction. Beyond that, health care manpower policy is very, very tricky. And my concern is that there's as much potential for mischief as there is for benefit when you start saying, "I like this kind of doctor. I don't like that kind of doctor."

Dan Leonard: I've got some in the back.

Gene Gagnon: Jonathan, Gene Gagnon with Sanofi Aventis. Great presentation on the cost of economic health insurance. I just raise the question of the same approach, of a cost-effective approach. You mentioned co-pays, and raising co-pays on drugs, and yet there's an experiment going on where 41 employers are now adopting a lowered co-pay to get better compliance among the employees with their pharmaceuticals. Taking your model and then adding also a cost-effective co-pay

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approach—in other words, if drugs are more cost-effective, they should have a lower co-pay, and other parts of the health care system might have a higher co-pay. Do you see what I'm saying? Using your same analysis with the co-pays to get better bang for the technology that you're using.

Jonathan Gruber, Ph.D.: This is actually very related to the last question, which is, once again, ideally we would actually target the co-pays. We don't even have to do drugs versus anything. We could target to one drug and not another drug. Ideally, we'd really target it to what's effective and what's not. The problem is that's in the eye of the beholder. And what's tricky is, on the one hand, drugs may be a more cost-effective way to treat things. On the other hand, typically we think that people are more price-sensitive in their use of drugs than they are in their use of other medical services, and that people tend to excessively use pharmaceuticals as their price is cheap more than they excessively use doctors' visits, which suggests you should actually have a higher co-payment on prescription drugs.

I don't want to promote one or the other, but I think that you're asking exactly the right question. But that's what we have to think about. What I've read here is a framework for thinking about things, not a specific proposal to have five dollars on this and eight dollars on that. It's a framework, and we need to think about where should the co-payments be high

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and where should they be low. Quite frankly, on prescription drugs, I think the evidence is that we'd probably do better to have it a bit higher than on things like doctors' visits, but that's my reading of the evidence.

Dan Leonard: Any further questions?

Well, this has been a good dialogue. And thank you very much for your very thought-provoking presentation.

[Applause]

Please come back at 4:30 for our presentation from Dr. John Goodman. Thank you very much.

[END RECORDING]