

Tax Policy and the History of the Health Insurance Industry

Robert B. Helms*
Resident Scholar
American Enterprise Institute

TAXES AND HEALTH INSURANCE: ANALYSIS AND POLICY

Conference Sponsored by
The Tax Policy Center and the American Tax Policy Institute
The Brookings Institution
February 29, 2008

Robert B. Helms
American Enterprise Institute
1150 Seventeenth Street, NW

* I would like to thank my research assistant Tal Manor and Tom Miller, Ted Frech, and Warren Greenberg for help in tracking down historic references and data.

Washington, DC 20036
rhelms@aei.org

“Long before the Christian era, it was the custom among the more affluent people in [ancient China] to pay the doctor as long as they continued in good health. When disability overtook them, the medical man’s compensation was stopped, and if his ministrations were unavailing in effecting recovery, the executioner relieved the doctor of his cares.”¹

For the last six decades insurance coverage for health-related expenditures has been provided primarily by policies offered through one’s place of employment. In 2006, employer-based insurance covered 161.7 million people, approximately 62.2 percent of the nonelderly population.² Individually purchased policies covered an additional 6.8 percent of the nonelderly while public programs covered 17.5 percent. This left approximately 18 percent without any health coverage.³ By contrast, in 1940, before World War II, only 9 percent (12.3 million) of the population had any form of coverage for medical expenses.⁴ By any definition, the dominance of employer-based health insurance coverage means that it has played an important role in the economic performance of the health care sector with major influences on both the demand and supply of medical services and products. As a consequence, the role of private health insurance must be a central part of any serious discussion of health care reform, the kind of reform that the country now seems ready to discuss.⁵

The purpose of this chapter is to explore the historical development of the private health insurance industry with special emphasis on the role of tax policy in affecting the economic performance of the industry and the health delivery system. While our approach is historical, our main objective is to consider the future role that tax policy might play in bringing about effective and efficient reform. We will explore the historical development of the health insurance industry, review some of the economic

literature explaining this development, and consider the implications of changes in tax policy on the future of the health reform debate.

The Growth of the Health Insurance Industry⁶

The period of years during World War II provided some important changes in both national policy and medical technology. As a consequence, the war serves as a convenient dividing point for looking at the history of the health insurance industry.

The Pre-war Period

While it is possible to find examples of early forms of accident and marine insurance in ancient China and nineteenth century America,⁷ the major development of modern health insurance in the United States had its origins in the depression years in the early 1930s. With incomes and employment dropping during the depression, hospitals were faced with reduced revenue and occupancy. As a protection for their revenue, several local hospitals began to develop what became known as “hospital service plans,” plans that collected small payments from employees of large firms and school districts in exchange for the promise to provide hospital care if needed. Morrisey reports that 26 such plans were in operation by 1933.⁸ The growth of these plans prompted the American Hospital Association (AHA) to establish a commission to set standards and approve the plans. Several criteria for approval -- e.g., that the plans be non-profit, provide coverage for all physicians and hospitals in an area -- helped to reduce competition among hospitals.⁹ The AHA and the hospitals also were active in the passage of enabling legislation in the states that allowed these plans to operate as non-profits, to be tax-exempt, and to be free of much state insurance regulation.¹⁰ The AHA commission adopted the name Blue Cross in 1946.

The early development of health insurance for physician services also started in the 1930s but followed a somewhat different path than that of hospital insurance. Most physicians, represented by the American Medical Association (AMA), were strongly opposed to any form of health insurance since they saw it as a threat to their income. As Thomasson points out, they were spurred to develop their own version of prepaid plans for physician services because of the threat they saw from the growth of hospital insurance and the continuing advocacy by some to expand Social Security to provide compulsory health insurance.¹¹ The AMA also lobbied for enabling legislation in the states but insisted that these plans provide indemnity coverage, a type of payment that paid the physician a fixed amount. This allowed the physician to “balance bill” the patient and retained the physician’s ability to charge different prices to different patients.¹² The AMA plans adopted the name Blue Shield in 1946.¹³

Health insurance provided by commercial insurance companies had its major growth in the post-war period. As late as the 1920s, hospitals were viewed as dangerous places where people went to die. These perceptions changed gradually in the 1930s with improvements in hospital management, higher professional standards for physicians, and the development of sulfur drugs to help control infections. Commercial companies in the business of selling insurance, who had previously regarded health insurance as a high-risk venture, began to notice the growing success of the Blue Cross and Blue Shield plans and began to experiment with their own commercial products.¹⁴ Policy changes and medical advances during the war would combine to accelerate the growth of health insurance in the post-war period.

Two Events during World War II

Alexander Fleming first published his discovery of penicillin in 1929, but it was not until 1940 that Howard Florey and Ernst Chain developed a method to manufacture it in a useful form. This led to highly successful clinical trials in 1940 and 1941, the provision of penicillin to soldiers during the war, and large-scale production in 1946. This development, as well as the development of even more effective antibiotics (Prontosil in 1939, Streptomycin in 1944, Chloromycetin in 1947, Terramycin in 1950), were a major improvement in the control of infections and made it possible to greatly expand the use of surgery.¹⁵

Victor Fuchs points out that life expectancy in 16 developed countries increased from 39 years in 1940 to 60 years by 1970. He and Samuel Preston “. . . estimated that about two-thirds of the increase was attributable to better health technology and similar structural changes and only one-third to a rise in per capita income.”¹⁶ This and other advances in medical education and technology helped to change peoples’ perceptions that medical care might have positive benefits and be worth paying for (See Table 1). In other words, medical advances beginning in World War II helped increase the demand for medical care and health insurance as a means of paying for it.

Table 1: Major Advances in Medicine

1928	Alexander Fleming discovers penicillin
1932	Gerhard Domagk discovers the first sulfa drug, Prontosil
1937	Max Theiler develops vaccine for yellow fever; Daniel Bovet develops first antihistamine
1940	Howard Florey and Ernst Chain develop penicillin as an antibiotic
1940-41	Successful clinical trials for penicillin
1943	Selman Waksman discovers the antibiotic streptomycin
1946	Start of first randomized clinical trials of streptomycin for the treatment of

	tuberculosis; large scale production of penicillin
1950	Terramycin developed
1952	Open-heart surgery begins with implantation of artificial heart valves
1954	First successful kidney transplant; plastic contact lenses produced
1957	Albert Sabin develops a live polio vaccine; Clarence Lillehei devises first compact heart pacemaker
1963	Measles vaccine licensed for general use in the United States
1967	Christiaan Barnard performs human heart transplant; Rene Favaloro develops coronary bypass operation

Sources: *Historical Statistics of the United States, Millennial edition* (New York: Cambridge University Press, 2006) 2, Table Bd-A, 2-500-501; Melissa A. Thomasson, "From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance," in *Explorations in Economic History* 39 (2003) 236-237.

The second major development during World War II was a somewhat unintended change in tax policy. To prepare to fight a war in Europe and the Pacific, the Congress established the War Production Board to coordinate the production of war-related materials. This was a massive exercise in government management and control, an exercise forbidding the production of "non-essential" consumer goods and directing materials and labor to the production of planes, ships, weapons, and other war materials. This policy of command and control carried over into the economic sphere with the establishment of two agencies to control wartime inflation: the Office of Price Administration instituted a system of rationing and price controls, while the National War Labor Board instituted a system of wage controls and an elaborate procedure to assure wartime production by avoiding labor disputes. With a large increase in farm and industrial production and the recruitment of soldiers, the Board had its hands full attempting to control wages during a period of large labor shortages. Their immediate goal was to limit wage increases to 15 percent of wages in January 1941.¹⁷ While most unions had pledged not to strike, the attempts to keep war production going forced the board into a massive bureaucratic battle to establish rules about almost every aspect of

employment, e.g., wage rates, raises, inflation adjustments, overtime pay, vacation pay, and promotions.¹⁸

One of the issues the Board had to deal with was the growing use of employer-provided “fringe benefits” (primarily pensions and health insurance) that employers were using to attract labor when they were forbidden to raise wages. Faced with an almost impossible enforcement task, the Board seems to have taken the easy way out by adopting IRS rules that treated fringe benefits differently than cash wages. They ruled that the employer’s provision of pension and health insurance benefits were not subject to wage controls,¹⁹ a policy that reinforced the IRS rule that such benefits were not to be treated as taxable income. As one member of the board explained, “The problem though was that we had to keep down inflation. So we agreed to allow increases in various benefits that we felt would not be inflationary – vacations, insurance, and so on.”²⁰ There is no indication that the Board debated this policy or made any prediction of its future consequences. This is unsurprising since at this time the provision of health insurance was not widespread and its costs were small relative to worker incomes. Health insurance data shows that premiums were only 0.4 percent of disposable income in 1940. This later increased to 0.47 percent by 1945 and 2.91 percent by 1970 (Table 2).²¹

	Total Premiums	Disposable Personal Income	Ratio
1940	\$0.3	\$75.7	0.40%
1945	0.7	150.2	0.47%
1950	1.9	206.9	0.92%
1955	4.3	275.3	1.56%
1960	7.5	350.0	2.14%
1961	8.3	364.4	2.28%

1962	9.2	385.3	2.39%
1963	10.0	404.6	2.47%
1964	11.1	438.1	2.53%
1965	12.1	473.2	2.56%
1966	12.7	511.9	2.48%
1967	13.5	546.5	2.47%
1968	15.0	591.0	2.54%
1969	17.3	634.2	2.73%
1970	20.0	687.8	2.91%

Note: Total premiums include insurance company premiums as well as BCBS and other hospital-medical plans.

Source: Source Book of Health Insurance Data, 1971-1972. New York: Health Insurance Institute.

To anticipate our future discussions, it is worth noting that the War Labor Board and IRS rules established a limit on what could be provided as pension and insurance benefits. To explain the term, “insurance and pension benefits in a reasonable amount” that were to be excluded from salaries, the regulations said, “Amounts paid by an employer on account of premiums on insurance on the life of the employee . . . *may not exceed five per cent of the employee’s annual salary or wages determined without the inclusion of insurance and pension benefits* (emphasis added).²² This explanation is presented in a section defining terms relating to the exclusion of “insurance and pension benefits,” so the term “premiums on insurance on the life of the employee” is not restricted to life insurance. In fact, on the same page the regulations state,

Premiums paid by an employer on policies of group life insurance without cash surrender value covering the lives of his employees, *or on policies of group health or accident insurance* [emphasis added] . . . do not constitute salary if such premiums are deductible by the employer under Section 23(a) of the Code.²³

The limit on the tax treatment of employer-provided life insurance is still in place but the provision of health insurance has been open-ended since the passage of the 1954 legislation and the new IRS rules implementing that legislation.²⁴

The Post-war Period, 1946-1975

In retrospect it is easy to see that many of the social and economic upheavals during the war had large effects on the nation following the war. The nation's efforts to fight a global war had expanded industrial capacity in California and other areas, had resulted in a relatively large increase in labor force participation among women, had moved large numbers of workers from the agricultural mid-west and south to industrial areas, and incorporated a number of new technologies into the production process. Not only is this period known as, "the birth of the baby-boom," there were relatively large increases in employment, income, and economic growth over the three decades following the war (See Table 3). More people had higher incomes and were working in larger

Table 3: Population and Economic Growth in the Post-War Period, 1945-1975

	1945	1975	Change
Population, Millions ^a	140	216	+54.3 %
Women in the Workplace, Millions ^b	16.7 (1947)	37.1	+122.3%
Per Capita Disposable Income ^c	\$5,285	\$8,944	+69.2%

Sources: ^aPopulation: *Historical Statistics of the United States, Millennial Edition* (New York: Cambridge University Press, 2006) 1, Table Aa6-8;

^bWomen: *Statistical Abstract of the United States*, 1968 (Table No. 310) and 1977 (Table No. 627);

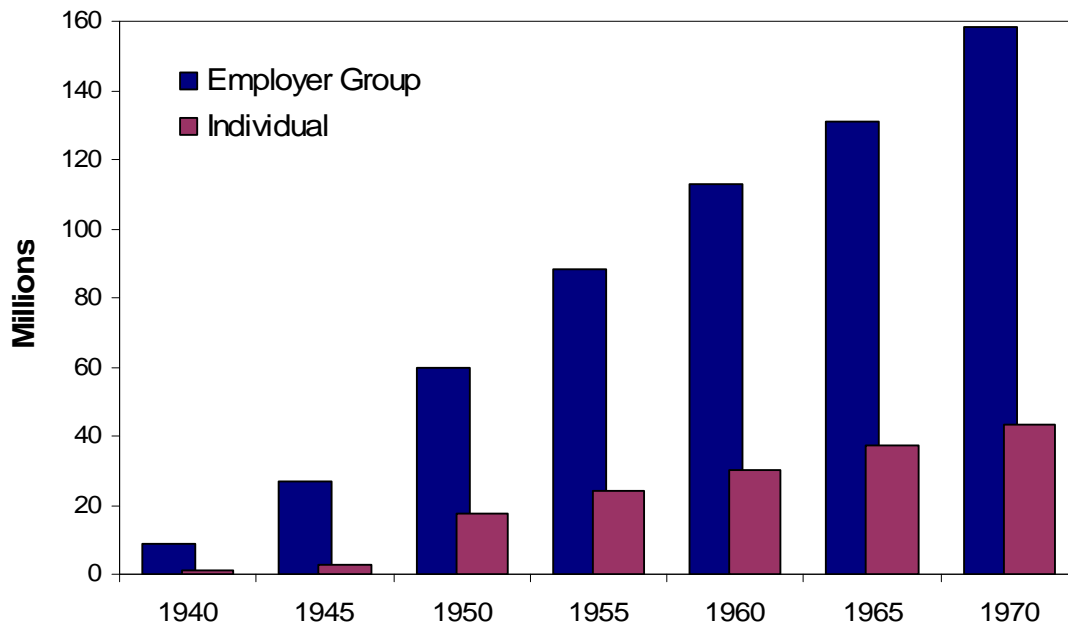
^cIncome: *Statistical Abstract of the United States*, 1990 (Table No. 695); amounts in constant 1982 dollars.

firms in the industrial and services sectors. With the pace of medical innovation increasing, the previously mentioned change in the public's perception about the productivity and value of medical care and products combined with the increased real

incomes to increase the demand for health insurance. As Paul Starr notes, “Real wages in manufacturing, not including fringe benefits, jumped 31 percent in the decade after 1945.”²⁵ People with higher incomes to protect were willing to pay for medical care that they expected would allow them to live longer and more productive lives.

Meanwhile, improvements in data collection and analysis allowed insurance firms to access the relative risk and set prices for potential groups of insurance buyers. Improvements in administrative procedures and record keeping allowed them to expand insurance coverage to larger markets. In addition, several factors lowered the cost of selling to employer groups relative to individuals. Employed people were relatively younger and healthier than the general population and it was administratively less expensive to sell insurance to employers or unions. The companies could avoid adverse selection since employees usually go to work for reasons other than to get health insurance. While the total number of people covered for hospital care increased from 12.3 million in 1940 to 175.4 million in 1970, Figure 1 illustrates that coverage of people in employer groups expanded relative to coverage of people who purchased individual, non-group policies.²⁶ This growth of employer-provided coverage relative to coverage purchased by individuals was unique to the health insurance market and did not occur in other lines of insurance such as fire, casualty, and automobile insurance, all of which were also expanding in the post-war period.

Figure 1. *Private Hospital Insurance Coverage, 1940-1970*



Source: *Historical Statistics of the United States—Colonial Times to 1970*, Series B 401-412. Employer Group is the total of persons covered by Blue Cross/Blue Shield plus insurance company group policies.

No summary of the history of health insurance would be complete without some mention of the role of unions. While the labor movement has a long history of interest in health and safety issues and legislation,²⁷ their ability to include health insurance benefits was enhanced by a series of policy decisions made by the War Labor Board (1945), the National Labor Relations Board (1949), and the Supreme Court (1949).²⁸ These rulings made it possible for unions to bargain for health benefits as part of wage negotiations under collective bargaining arrangements. The number of workers covered by health insurance negotiated by unions increased from 600 thousand in 1946 to 12 million workers and 17 million dependents by 1954, approximately a fourth of health insurance in the US.²⁹ There is no doubt that unions affected the early formation of health

insurance, but as Somers and Somers say, “. . . the record of labor influence on the medical care field is a mixed one.”³⁰

*Health Insurance in the Last Three Decades*³¹

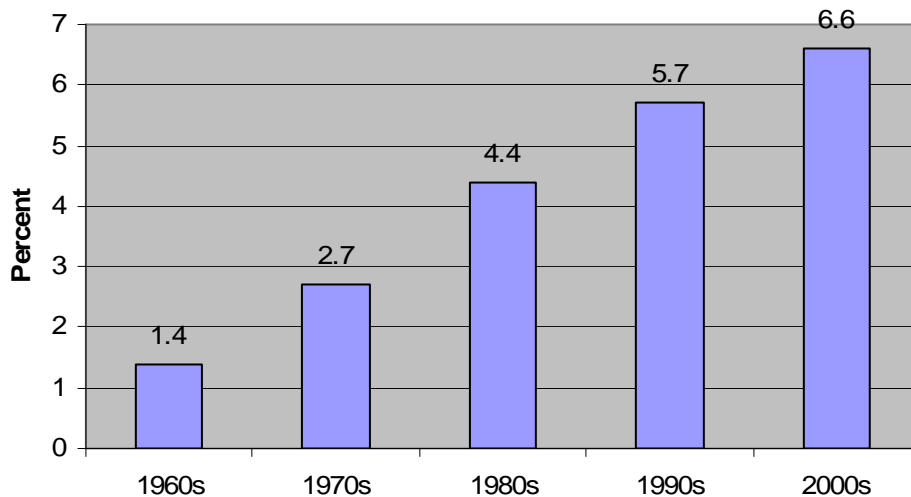
The history of health insurance since the mid-1970s has been dominated by the expansion of public health programs. Medicare and Medicaid were passed in 1965 as extensions of the Social Security Act and provided coverage for two large populations that had not been the focus of private health insurance, the aged (and disabled) and the poor.³² Both programs essentially adopted the fee-for-service payment methodology used by the Blues and most private insurance companies. These policies were advantageous to providers but helped to perpetuate the already weak incentives of consumers and providers to consider the cost-effectiveness of medical care. The result was a continuation of the cost-increasing tendencies of the US health care system from that time to the present, a tendency that was on a collision course with all payers, the government, employers, and individuals.

The Federal government responded to these cost increases by gradually applying administrative cost controls to hospitals and physicians servicing Medicare patients. State Medicaid programs responded by reducing reimbursement rates, restricting benefits and eligibility, and by doing everything they could to get the Federal government to pay a larger share of their costs.³³ These policies had the unintended effect of perpetuating the fee-for-service system of payments and putting more pressure on private insurance plans to control their own costs.

Meanwhile, the growth of employer-based health insurance coverage continued to grow in this period, both in absolute terms and relative to individual insurance. The costs

of these benefits have also increased relative to compensation. Consistent data over long periods of time are often difficult to construct, but a new study by Paul Jacobs for the Kaiser Family Foundation, based on the methodology developed by Len Nichols, shows that over five decades (1960-2006), “. . . employer payments for health benefits have increased as a share of total compensation in every decade, reaching 7.2 percent of compensation in 2006.”³⁴ Figure 2 shows the average annual shares of private group insurance (benefits as a share of total compensation) over five decades.

Figure 2: Private Group Health Benefits as a Share of Total Compensation, 1960-2006



Source: Paul Jacobs, “Wages and Benefits: A Long-Term View,” Kaiser Family Foundation, Snapshots: Health Care Costs, February 2008.

Several major changes affected the private health insurance industry in this later period, only two of which are directly related to tax policy. The first was the movement toward self-insurance prompted by both federal legislation and court decisions.³⁵ While the Blues lobbied for and obtained favorable legislation that exempted them from state premium taxes, the same had not been true of commercial insurance. Under federal law, a firm that could self-insure could avoid state premium taxes. While some large firms

could take over the entire operation of providing health insurance, the dominant arrangement involved an insurance company contracting with an employer to administer the health insurance plan while letting the employer assume the risk of paying the promised benefits. There are many variations on this arrangement, but they still fall under the same IRS provisions in the tax code that exclude the employer's cost from the income of the employee.

The second major development was the gradual growth, and then apparent decline of managed care. This movement was the result of both federal legislation³⁶ and employers' efforts to control the ever-increasing cost of health insurance. These changes were important because they forced the Blues and the commercial insurance companies to change the way they had typically paid providers, that is, hospitals, physicians, and suppliers of medical products. As with Medicare, insurers and employers were learning that they could not continue their previous practices of paying providers on the basis of costs and charges, an inherently inflationary method of payment. The managed care movement, which apparently reached its zenith in the mid-1990s, allowed health care plans to selectively contract with providers for the provision of care. Instead of paying on the basis of costs or charges, the plans could offer selected hospitals or groups of physicians exclusive access to their insured populations in exchange for discounted rates for medical services. Again, there were many variations in these arrangements, but they apparently played a role in reducing the rate of growth in medical costs from 1988 to 1996.³⁷ In fact, their very success may have attributed to their decline, commonly called, "the managed care backlash," the apparent movement away from the use of selective contracting and other unpopular cost-saving practices adopted by employers. Morrisey

reviews the empirical literature on the effects of managed care and finds evidence that managed care and the market competition it promotes is continuing to have an influence on market performance.³⁸

The third major development was the emergence of a new form of health insurance that combined the features of catastrophic coverage and high deductibles with tax-favored savings accounts that could be used to help pay the high deductibles.³⁹ This new movement is the result of two pieces of legislation that established Medical Savings Accounts (MSAs) in 1996⁴⁰ and Health Savings Accounts (HSAs) in 2003.⁴¹ It should not be surprising that there is little rigorous research about the performance of these new forms of health insurance. Morrisey reviews what we do know and reports that, “As of 2005, approximately 1 percent of insured adults had a CDHP, and another 9 percent were estimated to have HSAs that were eligible for CDHPs.”⁴² More recent data from a 2007 survey shows that 5 percent of covered workers are in a high-deductible health plan.⁴³

Paul Feldstein mentions one additional influence that may have worked to decrease the demand for health insurance beginning in the 1980s.⁴⁴ Tax law changes reduced marginal tax rates from a high of 87 percent in 1963 to approximately 39 percent today. This would have worked to reduce the tax advantage of employer-based health insurance, especially for those with the highest incomes. It follows that if MTRs are increased in the future, as several presidential candidates are promising, then the net price of employer-provided health insurance will again be reduced.

Economic Studies of the Effects of Tax Policy on Health Insurance⁴⁵

Having surveyed the history of health insurance in the US, we now turn to the question of what effect tax policy may have had on this development. To put it mildly, and too simply, there seems to be some disagreement about the role of tax policy with the economists on one side and the non-economists on the other. The extreme of the latter view can be illustrated by a quote from Cunningham: “The tax preference didn’t spawn the group health insurance market any more than federal highway construction gave birth to the automobile”.⁴⁶ His argument is that early post-war expansion of health insurance occurred at a time when employers were not contributing much to the cost of the premiums.⁴⁷

In contrast, the leading textbooks in health economics, as illustrated in the quotes below, list the exclusion of employer-based health insurance from taxable income as a major cause of the absolute growth in coverage and the diversion of that coverage to group policies offered by employers.

- Phelps: *The cumulative effects of the federal income tax subsidy of health insurance could be very large indeed. ... In the aggregate, it seems possible that the health sector would be at least 10 to 20 percent smaller without the tax subsidy for health insurance. Least this seem “small,” we can translate that difference into something that represents 1.5 to 3.0 percent of the gross national product.*⁴⁸
- Morrisey: *The tax treatment of employer-sponsored health insurance is a key factor in the structure of U.S. health insurance markets.*⁴⁹
- Feldstein: *The favorable tax treatment of employer-paid health insurance lowers [in original – lowered would be more correct] the price of insurance and led to a much greater demand for insurance than would have otherwise occurred. . . . Government tax policy has stimulated the demand for health insurance and has increased its comprehensiveness.*⁵⁰
- Folland, Goodman, and Stano: *One of the most important factors in the increased demand for health insurance in the post-World War II era has been the tax treatment of health insurance.*⁵¹

The basic economics of how tax policy increases the demand for group health insurance is straightforward.⁵² Tax policy subsidizes the purchase of health insurance in

two ways: first, by allowing the deduction of a limited amount of medical expenses and health insurance premiums from taxable income; and second, by excluding the value of employer-provided insurance from the employee's taxable income for the income tax and Social Security and Medicare payroll taxes. Like wages and other costs, the cost of health insurance to the employer is deductible as a business expense. The tax exclusion is the more important. In the latest budget estimates of tax expenditures, the business deduction was estimated to be \$4.8 billion in 2007 while the exclusion from employee income was estimated to be \$133.8 billion.⁵³

Tax policy increases the demand for health insurance by providing a government-funded discount for health expenditures and employer-provided health insurance. The higher the marginal tax rates (MTR) faced by an individual, the greater the amount of the discount. Because the tax subsidy lowers the net cost of a given level of health insurance, an employee rationally would prefer additional dollars spent on health insurance rather than on wages. An employee would have to pay taxes on the additional wages (at his or her MTR) but not on the health benefits.

How high are MTRs and the resulting discounts on health insurance purchased by the employer? According to Feldstein and Allison, the effective MTR for 1969 ranged from 13 percent for incomes under \$1,000 to 36 percent for incomes over \$25,000. They estimate that the total tax subsidy in 1969 was \$2 billion, including \$1.63 billion in reduced revenue and \$339 million from individual insurance payments. This is a 15 percent discount from the \$15.7 billion total health insurance premiums in 1969.⁵⁴ Writing in 1981, Feldstein reported that updates of these estimates indicate that the tax subsidy for 1978 exceeded \$10 billion on insurance premiums totaling \$42 billion, which

implies a 24 percent discount.⁵⁵ A more recent study by Gruber and Lettau using data from 1985 through 1995 finds an average tax price of 0.644 (a dollar of health insurance cost only 64 cents) which implies an average MTR of 35.6 percent.⁵⁶

Feldstein and Allison conclude their study by saying that the subsidy "causes a substantial revenue loss, distributes these tax reductions very regressively, encourages an excessive purchase of insurance, distorts the demand for health services, and thus inflates the prices of these services."⁵⁷

A second major empirical study that deals explicitly with the early post-war effect of tax policy on health insurance has been done by Melissa Thomasson.⁵⁸ She points out that the policies adopted by the WLB and the IRS in the war years (1943) may have had limited impact after the war due to changes in IRS rulings and confusion over exactly what could be excluded from employee income. This confusion was finally eliminated in 1994 by the IRS rules implementing the new legislation.⁵⁹ Thomasson uses this change in policy and two household surveys by the National Opinion Research Center (NORC), one conducted before the change (1953) and another four years after the change (1958), to measure the effects of the tax change.⁶⁰ She combines this data with premium information from a large health insurance company and estimates of each household's marginal tax rate (MTR) to measure the effect of the tax change on the probability that each household will have health insurance. On the basis of her analysis of the change in household behavior over this five year period, she presents several conclusions, all of which give strong support to the argument that the tax treatment of health insurance had a major effect on the demand for health insurance and the growth of employer-based coverage. As a result of the tax subsidy, she found the following effects:

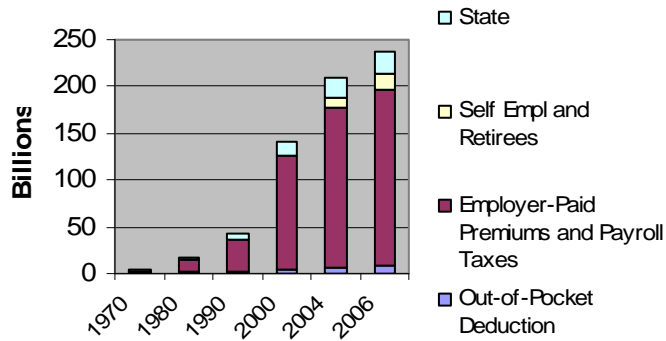
- The demand for group health insurance increased;
- The tax subsidy increased the amount of coverage purchased by 9.5 percent;
- There was a shift from individual insurance to group insurance;
- Households with group policies bought larger amounts of coverage after the tax subsidy was enacted; and,
- Households with higher marginal tax rates were more likely to have group coverage, and purchased larger amounts of coverage, than they did before 1954.⁶¹

It is also worth noting that Thomasson did another empirical study of the demand and supply of health insurance using state data from 1931-1955. This study led her to the following conclusion:

[T]he growth of the health insurance market between 1930 and 1950 *resulted from no single force* [emphasis added], but rather the simultaneous occurrence of a number of factors. Starting from the prepayment schemes fostered by the hospitals in the early 1930s, health insurance grew into its own as improvements in medical technology stimulated the demand for health insurance, and insurance companies began offering insurance to employee groups. Government policy in the 1940s and 1950s reinforced this trend, and cemented the employer-based system of private health insurance that the United States has today.⁶²

One additional set of data is worth noting because it presents evidence about the relative growth in tax subsidies over the last three decades. By combining estimates from three sources, Figure 3 shows the total tax expenditures for health insurance from 1970 through 2006.⁶³ There are two important points to notice about tax expenditures: one, the

Figure 3: Health-Related Tax Expenditures, 1970-2006
Billions



Sources: CBO, The Lewin Group.

largest component, and the one that has been growing the fastest, is the exclusion of employer-paid premiums and payroll taxes from federal income taxes. The second is the rate of growth in the total in the last decade. Since 2000 these estimates show that total tax expenditures have been increasing on average about \$16 billion each year. In a separate estimate, Sheils has estimated total tax expenditures to grow to \$294 billion by 2009.⁶⁴ With more people moving into higher tax brackets and more people exposed to the Alternative Minimum Tax, there is every reason to believe that the tax advantage for employer-based health insurance will continue to increase.

The Inefficiency of the Tax Treatment of Health Insurance

Numerous students of health policy have pointed out that the tax treatment of health insurance has created both winners and losers. In addition to all the providers earning extra income, the winners also include the additional employees and their dependents that are covered by employer-provided health insurance. Some have even attributed this tax policy for keeping health insurance predominately in the private sector, a path not followed by most other developed countries. Among the losers are all consumers who have had to pay higher prices for medical care and health

insurance. This includes all those with non-group health insurance, those with no health insurance, and all taxpayers who bear a larger tax burden to pay for the inflated costs of public health programs. Taking examples from economists, legal scholars, and physicians, the health policy literature has described this inefficiency in the health sector in at least the following three ways.

- The deadweight loss from the tax subsidy. As discussed and measured by Feldstein and Allison, this is the economist's technical notion of the net loss to society due to the higher prices and increased output induced by the subsidy. There is a net loss when it would be impossible for those who gained to compensate those who lost.⁶⁵
- The Benefit-Cost No Man's Land. Applying the logic of diminishing marginal returns, Havighurst and Blumstein have discussed the relationship between medical inputs and outputs. It always pays to apply more inputs into the medical field as long as the marginal benefits exceed the marginal costs. But, after some point, even while total benefits are increasing, the marginal benefits become less than the marginal costs. Havighurst and Blumstein call this area, "the benefit-cost no man's land. If inputs are extended even more, we enter the area of no additional benefits, referred to as, "flat-of-the-curve medicine." Havighurst and Blumstein argue that the tax subsidy of employer-based insurance has pushed us into the area of no additional benefits.⁶⁶ As Havighurst says, ". . . with unwise, unlimited tax subsidies distorting the design of private health insurance in cost-increasing ways, a great deal of preventable overspending on health care does indeed occur in the United States."⁶⁷
- Geographical Variations in Medical Spending and Outcomes. The considerable research of John E. Wennberg, MD, and his colleagues at Dartmouth has produced extensive data on medical spending and outcomes. Wennberg and his colleagues have used this data to show that there is little correlation between medical expenditures and medical outcomes in both large and small geographical areas. They have argued that medical practice, dominated by local custom and incentives to overspend, has resulted in enormous waste and inefficiency.⁶⁸

My broad conclusion from this summary is that tax policy change is a necessary (but not sufficient) condition to bring about efficient reform of our health care system. Trying to reform the behavior of consumers, providers, and employers through regulations, mandates, and controls, while leaving the distorting effects of tax policy in

place, will prove to be a long and frustrating exercise. If there is no change in tax policy, an increasing proportion of the relatively wealthy and healthy of the population will have more reason to take advantage of the discount for the purchase of group insurance provided by the tax exclusion. This will perpetuate the inefficient incentives that are behind the continuing increases in medical costs. Legislative language requiring all players in health markets to change their behavior will have little chance of success.

While tax policy reform may be a necessary condition for efficient reform, I take strong exception to those who say that any change will “destroy the employment-based system of health insurance.”⁶⁹ Our current system is the result of almost a century of gradual developments from forces affecting both the demand and supply of medical care and health insurance. Tax policy was not the only force affecting this system, but it exerted a strong influence on the development of labor markets and the health insurance industry. A change in tax policy, especially one that changes the open-ended nature of the tax exclusion, will be required to give everyone a reason to redesign health insurance in a more cost-efficient way. A return to the ancient Chinese model of health insurance might work, but it is even less likely that the Congress would be able to execute that policy than reform the present tax system.

¹ Edwin J. Faulkner, *Health Insurance* (New York: McGraw-Hill, 1960): 510-511.

² Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population survey,” *EBRI Issue Brief No. 310*, Employee Benefit Research Institute (October 2007): Figure 1.

³ As explained by Fronstin, details may not add to totals because individuals may receive coverage from more than one source.

⁴ Melissa A. Thomasson, “The Importance of Group Coverage: How Tax Policy shaped U.S. Health Insurance,” *American Economic Review* 93, no. 4 (September 2003): 1374. Thomasson’s source is Health Insurance Institute, *Source Book of Health Insurance Data* (1960).

⁵ A recent Commonwealth Fund survey found that 86 percent of those polled indicated that a candidate’s views on health care reform would be very important or somewhat important in deciding on whom to vote for president in 2008. See Sara A. Collins and Jennifer L. Kriss, “The Public’s Views on Health Care Reform in the 2008 Presidential Election,” *The Commonwealth Fund* (January 15, 2008): Figure 1.

-
- ⁶ This section relies on an earlier article of mine and several books and articles that explore in more detail the historical development of the industry. See, Robert B. Helms, “The Tax Treatment of Health Insurance: Early History and Evidence, 1940-1970,” in Grace-Marie Turner, ed., *Empowering Health Care Consumers through Tax Reform* (Ann Arbor: University of Michigan Press, 1999): 1-25; Faulkner, *Health Insurance*; Thomasson, “The Importance of Group Coverage;” Thomasson, “From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance,” in *Explorations in Economic History* 39 (2003) 233-253; Thomasson, *Health Insurance in the United States* (EH.NET Encyclopedia, edited by Robert Whaples, April 18, 2003). URL <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>, accessed 3/6/2006; Rosemary A. Stevens, “Health Reform in 2007: What Can We Learn from History?” URL http://www.ehcca.com/presentations/uninscong1/stevens_hl.doc, accessed 1/30/08.
- ⁷ Stevens, “Health Reform in 2007,”: 3; Faulkner, *Health Insurance*: 510-540.
- ⁸ Michael A. Morrissey, *Health Insurance* (Washington, DC: Health Administration Press, 2008): 5.
- ⁹ H. E. Frech III, *Competition & Monopoly in Medical Care* (Washington: The AEI Press, 1996): 102-130.
- ¹⁰ Thomasson, *Health Insurance in the United States*: 4.
- ¹¹ Thomasson, “From Sickness to Health:” 239.
- ¹² Ibid. Charging different prices based on ability to pay goes by several names: price discrimination, multi-part pricing, and Ramsey pricing. The practice can increase the revenue of the seller (physician) as long as reselling can be prevented. Most physician services are not physical products so are almost impossible to resell. For an explanation of price discrimination in medicine, see Rubin A. Kessel, “Price Discrimination in Medicine,” *Journal of Law and Economics* 1 (1959): 20-53.
- ¹³ Blue Cross and Blue Shield operated as separate organizations until their merger into the Blue Cross and Blue Shield Association in 1977. Morrissey, *Health Insurance*: 11.
- ¹⁴ Thomasson, “From Sickness to Health:” 236.
- ¹⁵ *Historical Statistics of the United States, Millennial edition* (New York: Cambridge University Press, 2006): 2, Table Bd-A, 2-500-501;
- ¹⁶ Victor R. Fuchs, *The Health Economy* (Cambridge, MA: Harvard University Press, 1986): 280.
- ¹⁷ Beth Stevens, “Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector,” in Margaret Weir, Ann Shola Orloff, and Theda Skocpol, eds., *The Politics of Social Policy in the United States* (Princeton: Princeton University Press, 1988): 132-133.
- ¹⁸ Examples of these rules and proceedings can be found in War Labor Reports, *Reports and Decisions of the National War Labor Board* (Washington, D.C.: The Bureau of National Affairs, 4, 1943) LXIV.
- ¹⁹ Ibid, “To the extent that an insurance and pension benefit inuring to an employee is reasonable in amount, such benefit is not considered as salary as defined in Section 1002.6” Section 1002.8.
- ²⁰ E. Robert Livernash, as quoted by Stevens, “Blurring the Boundaries:” 133.
- ²¹ *Source Book of Health Insurance Data, 1971-1972*. New York: Health Insurance Institute.
- ²² Office of Economic Stabilization, *Regulations of the Part 4001 Relating to Wages and Salaries*, Issued October 27, 1942; amended November 5 and November 30, 1942, Section 4001.1 (h) (2), War Labor Reports 4, XII.
- ²³ War Labor Reports, *Reports and Decisions of the National War Labor Board*, Section 1002.8, LXVIII. See also, Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982): 311.
- ²⁴ P.L. 83-591, August 16, 1954; Internal Revenue Code of 1954, Section 106. For more information on the 1954 tax code, see Selma Mushkin, “The Internal Revenue Code of 1954 and Health Programs,” *Public Health Reports* 70, no. 8 (August 1955): 791-800.
- ²⁵ Starr, *The Social Transformation of American Medicine*: 313. See Table 2 on the gradual increase in premiums relative to disposable income.
- ²⁶ *Historical Statistics of the United States—Colonial Times to 1970*, Series B 401-412.
- ²⁷ Herman M. Somers and Anne R. Somers, *Doctors, Patients, and Health Insurance* (Washington D.C.: Brookings Institution, 1961): 232-246; Morrissey, *Health Insurance*: 3-10; Stevens, “Health Reform in 2007.”
- ²⁸ Thomasson, *Health Insurance in the United State*: 8.
- ²⁹ Starr, *The Social Transformation of American Medicine*: 312-313.
- ³⁰ Somers and Somers, *Doctors, Patients, and Health Insurance*: 237. It is interesting to note that Somers and Somers never mention the possibility that tax policy affected the development of health insurance.

-
- ³¹ For more complete descriptions of this history, see Starr, *The Social Transformation of American Medicine*, especially Chapters 3-5; Frech, *Competition & Monopoly in Medical Care*: 102-146; Morrisey, *Health Insurance*: Chapters 9-11.
- ³² Medicare- Title XVIII of the Social Security Act, United States Code §§1395-1395ccc, subchapter XVIII, chapter 7, Title 42. http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
Medicaid- Title XIX, United States Code §§1396-1396v, subchapter XIX, chapter 7, Title 42. http://www.ssa.gov/OP_Home/ssact/title19/1900.htm For an overview of these programs, see Morrisey, *Health Insurance*: 315-332, and 349-365.
- ³³ For a description of Medicaid financing, see Robert B. Helms, “The Medicaid Commission Report: A Dissent,” AEI Health Policy Outlook, January 11, 2007, available at <http://www.aei.org/publication25434>
- ³⁴ Paul Jacobs, “Wages and Benefits: A Long-Term View,” Kaiser Family Foundation, Snapshots: Health Care Costs, February 2008, available at <http://www.kff.org/insurance/snapshot/chcm012808oth.cfm>
- ³⁵ McCarran-Ferguson Act, 15 U.S.C. 20.
- ³⁶ HMO Act of 1973, 42 U.S.C. § 300e.
- ³⁷ Morrisey, *Health Insurance*: 158.
- ³⁸ *Ibid*, 172-173.
- ³⁹ Such plans are often called, “Consumer-Driven Health Plans (CDHP).”
- ⁴⁰ Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.
- ⁴¹ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173.
- ⁴² Morrisey, *Health Insurance*: 251.
- ⁴³ Gary Claxton, et al, [??Gabel, DiJulio, Pickreign, Whitmore, Finder, Jacobs, and Hawkins,] “Health Benefits in 2007,” *Health Affairs* 26, no. 4 (September/October 2007): 1413.
- ⁴⁴ Paul J. Feldstein, *Health Care Economics, 6th Edition* (USA: Thomson Delmar Learning, 2005): 122, 480.
- ⁴⁵ For a more complete discussion of effects of tax policy on health and labor markets, see Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (Washington, D.C.: Congressional Budget Office, 1994): 17-32. For a summary of more recent studies, see Morrisey, *Health Insurance*: 209-213.
- ⁴⁶ Robert Cunningham, “Joint Custody: Bipartisan Interest Expands Scope of Tax-Credit Proposals,” *Health Affairs – Web Exclusive* (September 18, 2002): W297.
- ⁴⁷ For a counter argument by a non-economist, see Beth Stevens, “Blurring the Boundaries,” 132-134. See also the direct response by Tom Miller, *Health Affairs – Web Exclusives*, October 8, 2002.
- ⁴⁸ Charles E. Phelps, *Health Economics* (Reading, MA: Addison-Wesley, 1997): 356-357.
- ⁴⁹ Morrisey, *Health Insurance*: 203. See also his chapter summary, 214.
- ⁵⁰ Paul J. Feldstein, *Health Care Economics*: 121, 122.
- ⁵¹ Sherman Folland, Allen Goodman, Miron Stano, *The Economics of Health & Health Care, 5th Edition* (Upper Saddle River, N.J.: Pearson Education, 2007): 221.
- ⁵² The following relies heavily on my previous article, Helms, “The Tax Treatment of Health Insurance:” 9-15.
- ⁵³ Office of Management and Budget, *2009 Budget, Federal Receipts and Collections, Analytical Perspectives*, available at <http://www.whitehouse.gov/omb/budget/FY2009/apers.html>.
- ⁵⁴ Martin Feldstein and Elisabeth Allison, “Tax Subsidies of Private Health Insurance: Distribution, Revenue Loss, and Effects,” in Martin Feldstein, *Hospital Costs and Health Insurance* (Cambridge, MA: Harvard University Press, 1981): Table 7.2, 208. Feldstein and Allison argue that these estimates are likely underestimates of the actual subsidies due to limitations of their data and model.
- ⁵⁵ *Ibid*. 174.
- ⁵⁶ As reported by Morrisey, *Health Insurance*: 211.
- ⁵⁷ Feldstein and Allison, “Tax Subsidies of Private Health Insurance:” 216.
- ⁵⁸ Thomasson, “The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance.” An earlier working paper version of this study is available at <http://www.nber.org/papers/w7543>
- ⁵⁹ Thomasson, “The Importance of Group Coverage:” 1374, referring to P.L. 83-591, August 16, 1954; Internal Revenue Code of 1954, Section 106.
- ⁶⁰ Each survey asked about the family’s prior year’s experience.
- ⁶¹ Thomasson, “The Importance of Group Coverage:” 1382.

⁶² Thomasson, *From Sickness to Health*: 251.

⁶³ Data for 1970 through 2000 is from Congressional Budget Office, *Projections of National Health Expenditures*, October 1992: 56. Data for 2000 is from a personal communication from John Sheils. Data for 2004 is from John Sheils and Randy Haught, “The Cost of Tax-Exempt Health Benefits in 2004,” *Health Affairs—Web Exclusive*, W4-109. Data for 2006 is from a personal communication from John Sheils, The Lewin Group.

⁶⁴ Personal communication from John Sheils based on estimates contained in John Sheils and Randy Haught, *President Bush’s Health Care Tax Deduction Proposal*, The Lewin Group, January 2007, available at <http://www.lewin.com/NR/rdonlyres/B45E2670-8A65-4817-B68B-83B818616DDF/0/BushHealthCarePlanAnalysisRev.pdf>

⁶⁵ Martin Feldstein and Elisabeth Allison, “The Welfare Loss of Excess Health Insurance,” in Martin Feldstein, *Hospital Costs and Health Insurance* (Cambridge, MA: Harvard University Press, 1981): 175-204.

⁶⁶ Clark C. Havighurst, *Health Care Choices* (Washington, D.C.: The AEI Press, 1995): 93-103.

⁶⁷ *Ibid*, 101.

⁶⁸ For information on the Dartmouth Atlas and their many publications, see their website at <http://www.dartmouthatlas.org/>

⁶⁹ See Robert B. Helms, “Mission Improbable: No One Is Going to Blow Up Health Insurance,” *Tax Notes* 111, no. 11 (June 12, 2006): 1262-1264.