

Cutting Health Care Spending: What is the Cost of an Excise Tax that Keeps People from Going to the Doctor?

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One of the most controversial issues for the health care reform conference between the House and Senate involves a steep excise tax on high-cost, so-called “Cadillac” insurance plans that the Senate included in its version of the legislation. Although the high-premium excise tax has met stiff resistance from the unions, and is not part of the financing package of the House bill, it has strong support from most economists (who believe we should tax all employee health benefits), within the administration, and from a number of commentators across the political spectrum. Supporters of the tax believe it will discourage “excessive” insurance and “bend the cost curve.”

There is, however, evidence to suggest that the excise tax will instead keep people from getting recommended and necessary medical care—particularly older people, those with low incomes and those in poor health. In addition, over time the tax will affect a broader segment of the population, thus reducing coverage for an increasing number of people. Unless other aspects of health insurance reform change the ability of insurers to control costs in some other way, reduced benefits due to the excise tax could even lead to worse health outcomes as some patients forego care for chronic conditions which, consequently, deteriorate.

Why might a policy that is widely praised by many experts have such negative effects? To answer that question, we will first describe briefly how the proposal would work. Next, we turn to the theoretical basis for the excise tax. Many economists believe that many Americans have “excess” insurance – more than they need. We will provide an overview of both the logic and evidence for this argument. Third, we will turn back to the bill itself, how it defines excess, and why that definition is badly flawed. In conclusion, we will explain why the supposed inequities of “excessive” insurance could be much more fairly addressed in other ways; and why there are ways to control costs that would have much less negative effects on the ability of sick people to get needed medical care.

How Does the Senate Bill Define Excessive Insurance?

Under the Senate legislation, “excess” insurance is defined by its price. Insurance would be considered excessive if, in 2013, its total premium would exceed \$8,500 per year for an individual, and \$23,000 for a family. The value of coverage above the threshold would be taxed at a rate of 40 percent.¹ Thus, if an employer and employee combined to purchase coverage for \$25,000, the insurer would have to pay an \$800 tax (and of course would only provide \$24,200 in benefits, at best!). Or, if an employer self-insured, but its average expenses for employees who had family coverage were \$25,000, there would be an \$800 tax for each of those employees. Beginning in 2014, the thresholds would be raised each year by the annual increase in the

¹ “The Patient Protection and Affordable Care Act: Detailed Summary,” Democratic Policy Committee, November 2009. Accessed at: <http://dpc.senate.gov/healthreformbill/healthbill04.pdf>

consumer price index (CPI) plus one percentage point. In most recent years, that would have been about three percent per year.

What level of benefits counts as “excessive,” therefore, will change over time. If health care costs rise more quickly than the thresholds, so by more than one percentage point above the CPI increase each year, any given benefit package will move closer to the threshold. Each year, more peoples’ existing insurance will become “excessive.”

Let us assume that insurance premium trends after 2009 will be similar to those from 2004-2009. In 2009, the average employment-related plan – not including separate coverage such as medical and dental² -- cost \$4,824 for individuals and \$13,375 for family coverage. Between 2004 and 2009, premiums increased by 6 percent per year, while the consumer price index increased by 2.5 percent per year.³ If those trends continued, the average individual premium in 2013 would be \$6,090 for individuals and \$16,885 for families. Therefore “excess” insurance would be defined by having premiums about 40 percent higher than the average price for individuals and 36 percent higher than the average for families.

If the 2004-09 trend continued after 2013, then, by 2019, the threshold could be 21 percent higher than the average premium for individuals’ core health benefits, and 18 percent higher than the average for families. Yet it will be closer to the average if we count non-core benefits such as medical and dental as well. A very large share of workers will have their coverage hit by the tax, unless cost increases suddenly moderate. Much as the Alternative Minimum Tax started as a tax on the very rich and eventually extended to an increasing portion of the middle class, the “Cadillac plan” tax will over time cover an increasing number of midsize sedans.

The Congressional Budget Office and advocates for the excise tax clearly are assuming that premiums will increase more slowly. Thus one major issue is whether there are credible reasons to anticipate that pleasant development. Advocates for the excise tax believe it will actually cause that development. Skeptics will point out that the faster costs rise, the more peoples’ benefits will become “excessive,” and so subject to penalties. *From this perspective, the excise tax is an automatic cost control mechanism targeted on covered workers: if costs rise more quickly than expected, the government will force employers to cut benefits.* The important question, however, is what would be the effects of these cuts.

What Would the Excise Tax Do?

The excise tax should give the federal government new revenues. If the amount paid for any group of employees exceeds the targets, employers or insurers will pay the tax. Much more likely, employers will reduce the value of the coverage that they provide.⁴ A spokesman for the

² See Kaiser Family Foundation, “Employer Health Benefits Survey 2009: Survey Design and Methods” at <http://ehbs.kff.org/?page=charts&id=2&sn=15&p=1>.

³ Figures taken from charts 1 and 2 of “Survey of Employer Health Benefits 2009. Accessed at <http://ehbs.kff.org/pdf/2009/7981.pdf>.

⁴ Towers Perrin, a global consulting firm, surveyed 433 human resources executives. 87% reported that, “if health care reform increases employer costs,” their companies will reduce benefits. Towers Perrin Employer Survey, “Health Care Reform 2009: Leading Employers Weigh In.” September 17, 2009, Exhibit 10, p6. Accessed at http://www.towersperrin.com/tp/getwebcachedoc?webc=USA/2009/200909/HCR_Pulse-Survey_Sept-09_Final.pdf

U.S. Chamber of Commerce, which opposes the tax, said that employers “will likely reduce worker benefits to avoid incurring the taxes or reduce wages to make up for the increased taxes.”⁵

If employers compensate their employees for the lesser benefits by raising their wages, then the government will get new revenue from taxing the higher wages. If employers instead choose to distribute higher profits, these too will be taxed. These effects will occur regardless of whether the new tax creates any incentive to lower overall health care costs. The Congressional Budget Office estimated that the language in the Senate bill would increase federal revenues by \$149 billion over fiscal years 2013 through 2019. These revenues are part of how the Senate bill is projected not to increase the federal deficit. In essence, expansion of insurance to some people is to be financed, in part, by reducing insurance for others.

As we can expect employers to reduce the value of the insurance they provide, that raises two questions:

1) How will the value of insurance be reduced? Some might, instead or in addition, reduce contributions to flexible spending accounts – a policy that might be justified because FSAs do favor higher-income workers. But a survey of employers by the consulting firm Mercer found that of the 63 percent of employers who said they would make changes to avoid the tax, 75 percent would raise deductibles or copayments to bring down the costs of premiums.⁶ In current insurance bargaining, increased cost sharing is the major tool employers and insurers have to reduce costs.

2) What will employers do with the money they divert from spending on health benefits in order to avoid the new tax? Advocates for the tax argue this money will be transferred into wages for their employees. For example, wages rose in the 1990s as insurance premiums rose more slowly.⁷ The Congressional Joint Committee on Taxation assumes that most of the revenue from the tax will come from increased income and payroll taxes on the wage increases that will be passed on to workers when their benefits are cut.⁸ Therefore, in theory, people will be able to compensate for *some* of the lost coverage—for example, they will be better able to pay out-of-pocket for higher cost sharing.

There will certainly be some situations where collective bargaining agreements are renegotiated and benefit cuts will result directly in wage increases. The wage increases of the 1990s, however, were part of an unusual increase in total compensation that far exceeded the size of health care cost constraint. Moreover, the most significant improvement in wage trends occurred among

⁵ “Unions, Business Oppose Tax on 'Cadillac' Care,” Esmé E. Deprez, Business Week, November 23, 2009, Accessed at: http://www.businessweek.com/bwdaily/dnflash/content/nov2009/db20091123_720329.htm

⁶ “Survey: 'Cadillac tax' would lead employers to trim costs,” Julie Appleby, Kaiser Health News, Accessed at: <http://www.mcclatchydc.com/homepage/story/79955.html>

⁷ “'Cadillac' tax isn't a tax – it's a plan to finance real health reform.” Jonathan Gruber, Washington Post, December 28, 2009, A15.

⁸ “Estimated Revenue Effects of the Revenue Provisions Contained in the ‘Patient Protection And Affordable Care Act,’” The Joint Committee on Taxation, November 18, 2009, Accessed at: <http://www.jct.gov/publications.html?func=startdown&id=3635>

lower-wage workers who are least likely to have medical benefits.⁹ In the context of current unemployment of over ten percent, the assumption that benefit cuts will result directly in one-to-one wage increases is heroic, to say the least. Economists assume that wages and benefits are simply interchangeable, but human resources specialists in corporations do not expect to follow the theory. Thus, when asked what they would do if health care reform actually gave savings, only nine percent of respondents in Towers Perrin's survey said they would "increase salaries/direction compensation." Seventy-eight percent said they would "retain savings in the business," and twenty three percent said they would "pass on savings to customers."¹⁰ Mercer reported that "just 16 percent of the employers it surveyed during a recent Web seminar on health care legislation would be 'likely' or 'very likely' to raise wages if they cut benefits to avoid being hit by the excise tax. Another 65 percent said they would be 'unlikely' or 'very unlikely' to raise wages to offset benefit cuts, while 20 percent were 'not sure'."¹¹

The excise tax therefore will surely reduce resources available for employees of affected companies to obtain medical care. It will certainly transfer increased taxes from those workers to the federal government, and is quite likely also to reduce those workers' total compensation. It therefore will make it more difficult for those workers to obtain medical care.

Advocates for the excise tax nevertheless believe that overall it will have beneficial but less direct effects. Indeed, CBO "Director Douglas Elmendorf has stated that changing the tax treatment of high-cost health insurance to reduce its attraction is one of 'two powerful policy levers' the federal government has available to encourage changes in medical practice and thereby slow the increase in health care costs."¹² He and other proponents of the tax believe that causing employers to reduce benefit packages will help transform the medical care system, in a good way. Skeptics believe, in the words of a report from the Commonwealth Fund, that "there is little empirical evidence that such a tax would have a substantial effect on health care spending. Unless it is carefully designed, it could penalize employees in plans with sicker, higher-risk, or older workers and firms in high-cost areas."¹³

The roots of that dispute involve one line of economic thinking about why costs in the United States are so high, so we turn now to that theory. The theory is promoted with fervor by much of the economist community, and so seen as true by many journalists. But the other experts have good reasons for doubt.

⁹ "Employer Health Costs Do Not Drive Wage Trends," Lawrence Mishel, Economic Policy Institute Issue Brief 269, January 6, 2010.

¹⁰ "Health Care Reform 2009" op cit. fn 4, Exhibit 12, p. 7.

¹¹ Survey Finds Employers Are Unlikely to Raise Wages If Health Care Excise Tax Is Enacted," Richard Rubin, CQ Today Online News, December 4, 2009.

¹² Paul N. Van de Water, "Excise Tax on Very High-Cost Health Plans Is a Sound Element of Health Reform: Congress Should Retain Tax, But Improve It Further," Center on Budget and Policy Priorities, November 10, 2009. Accessed at: <http://www.cbpp.org/cms/index.cfm?fa=view&id=2957>

¹³ Karen Davis, Stuart Guterman, et al, "Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of House of Representatives and Senate Health Reform Bill," November 20, 2009, Commonwealth Fund. Accessed at: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Nov/Starting-on-the-Path-to-a-High-Performance-Health-System.aspx>

The “Cadillac Tax” and the Theory of Excessive Demand

The debate about the excise tax is based on earlier debates about cost sharing: requiring that consumers pay some of the cost of health services out of pocket. Major differences among health care plans typically involve the level of cost sharing: whether and how large a deductible is charged before insurance pays for either all services or specific services; whether services are accompanied by co-pays (e.g. \$50 to visit the Emergency Department) or coinsurance (e.g. 20% of the bill, as for many Medicare services) and the size of those charges; and whether there is any cap on total cost-sharing per patient or family. In a careful review of evidence about cost-sharing, Dahlia Remler and Jessica Greene explain that:

“The traditional economic argument for cost-sharing is as follows: In a regular market, goods and services are bought without insurance, and consumers trade off the benefits of purchasing more and better goods with the costs... Only goods whose benefits exceed their costs are consumed. In contrast, with health insurance, consumers pay little or none of the health care costs. So they consume more health care than they would if they paid for the care in full. The cure for the excessive care is cost-sharing, the partial undoing of insurance to bring the health care consumed closer to what it would be without insurance.”¹⁴

The argument that “third-party payment” by insurance causes the first party (the patient) to worry less about purchasing services from the second party (the health care provider) is obviously true: this “problem” with insurance is the *point* of insurance. So the theory applied properly (that is, not as an argument against all insurance in principle) requires what might be called a “goldilocks” level of insurance: enough to protect people against unaffordable costs, and guarantee access to needed care, but with enough cost-sharing to make people stop and think about whether care is really worthwhile. The theory also requires that people be able to judge what is worthwhile, and so be prudent purchasers.

The RAND Experiment

What would make cost sharing “just right?” Goldilocks would want cost sharing which lowers costs but does not worsen health. The empirical support usually cited for the belief that higher cost sharing for health care can lower costs without worsening health is the RAND Health Insurance Experiment (HIE).¹⁵ The HIE was a large study conducted in the late 1970s and early 1980s to determine how and to what extent consumer cost sharing affected the behavior of insured health care consumers. Under the HIE people were assigned to groups with different levels of coinsurance ranging from free care to 95 percent coinsurance up to a cap. Their use of health care services was then tracked over time. Not surprisingly, the HIE found that people who had to pay more out of pocket for health care used less. More surprisingly, the experiment found

¹⁴ Dahlia K. Remler and Jessica Greene, “Cost-Sharing: A Blunt Instrument,” *Annual Review of Public Health* 2009, 30: 293-311, quote 295-96.

¹⁵ The most thorough report on the HIE is Joseph P. Newhouse, “*Free for All? Lessons from the RAND Health Insurance Experiment*,” Cambridge, MA: Harvard University Press, 2009. There may be hundreds of other articles.

that the average person who had higher cost sharing and used less care did not seem to suffer ill effects. This finding had a deep and lasting effect on the economics profession.¹⁶

Yet the finding that cost sharing was not as damaging as some analysts believed beforehand should not be interpreted as making quite so strong a positive case for cost sharing. Perhaps most importantly, the HIE found negative health effects for people who were most likely to be prevented from seeking care due to having to pay out of pocket, and most likely to need care due to having chronic conditions. In particular, higher cost sharing was associated with increased mortality rates for lower-income persons with elevated blood pressure.

The experiment also found that those who used less care did so pretty much across the board, using less care than experts considered necessary to about the same extent that they used less care than experts considered superfluous. This contradicts the assumption that, if faced with cost constraints, consumers are capable of being prudent purchasers. In addition, “Cost sharing ‘worked’ almost entirely by reducing the number of medical care episodes for which treatment was sought.”¹⁷ Once a person entered the medical care system, cost sharing had little effect on consumption of care. This implies that the purpose of cost sharing is to make people less likely to go to the doctor, rather than to make sure people only get necessary care if they go to the doctor, yet the patterns of foregone care do not seem to suggest that works very well.

The study also did not determine whether the foregone care might have led to worse results if it had lasted longer. The seeming contradiction between the fact that some supposedly effective care was missed and the absence of measured consequences for healthier, wealthier enrollees could be due to not having enough time for relatively rare negative effects to develop.¹⁸

It is also possible that people who were most likely to have negative health effects from cost sharing, and had the resources to do better if they left the experiment (unlike the poor), opted out. John Nyman has shown that the rate of attrition during the study from the cost-sharing arm was 16 times greater than that of the free care arm. A reasonable hypothesis is that people who faced cost constraint in the experiment and wanted better coverage reverted to their pre-experiment coverage to avoid paying the cost sharing, and that we do not in fact know how their health would have been affected had they been forced to stay with the study and consume less care.¹⁹ The HIE researchers argued that the attrition rate was unlikely to bias results because the group that left the experiment had similar demographic characteristics to the group that stayed. But a massive literature shows that, while demographic characteristics are related to health care costs, they are not a sufficient control against adverse selection of individuals into or out of health insurance plans.

¹⁶ Evan Melhado, “Economists, Public Provision, and the Market: Changing Values in the Policy Debate.” *Journal of Health Politics, Policy and Law* 23(2), April 1998, pp. 216-63.

¹⁷ Thomas Rice and Kathleen R. Morrison. “Patient Cost Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform,” *Medical Care Research and Review* 51 (1994), pp. 235-287; quote p. 243.

¹⁸ *Ibid* p. 245; the other possibilities are that the care effectiveness categories were not accurate, which would raise doubts about the whole experiment, or that physicians provide harmful care. Many health service researchers believe the latter argument; the question is why that does not happen as much if there is cost-sharing (supposedly).

¹⁹ John Nyman, Health Plan Switching and Attrition Bias in the RAND Health Insurance Experiment, *Journal of Health Politics, Policy and Law* 2008 33(2):309-317.

A further concern is whether the data had “external validity” – could it be generalized beyond the experimental setting. The most damaging critique at the time was that there was no supplier response to changes in demand. The HIE was too small, in any one market, to be noticed by suppliers seeking to maintain their incomes. As Rice and Morrison explain, “Each site had an average of only about 1,000 participants, many of whom were assigned to insurance plans that were as generous or more generous than those they had previously owned.”²⁰ As a result, physicians and hospitals saw no effect on incomes, and had no reason to adopt cost-increasing strategies such as inducing demand for follow-up services once patients entered the medical system, or simply raising prices. Canadian analysts, as Rice and Morrison note, have been skeptical of cost sharing because of evidence of such provider responses in their system. Little data has emerged to address the question of whether providers could offset the demand-side effects of cost sharing.²¹

Moreover, the HIE data is almost thirty years old, and the comparisons made in the HIE do not fit the current insurance market. Today, there is little ‘free care’ without significant copayments left. Insurance has changed further with the development of forms of “managed care” such as utilization review (UR). Medical practice has changed dramatically, with new long-term treatments for chronic conditions (which may mean greater risk from cost-induced avoidance of treatment). Systemic risks from under-treating chronic illness may also be greater because of rising prevalence of those conditions. A given coinsurance rate should also inhibit consumption more at the much higher price levels of 2009 compared to 1979. For these and other reasons, as a report from RAND itself concluded in 2006, “it is impossible to know whether a similar experiment undertaken today would produce similar results.”²²

The RAND experiment is a classic piece of research, but basing a major health care reform on data which is about thirty years old, and involved a total of fewer than 6,000 people across six sites with insurance for three to five years, is clearly not a great idea. It is made less wise because, as this discussion shows, the HIE evidence itself does not clearly support higher cost sharing.

Evidence Since the RAND Experiment

No study since the RAND HIE has manipulated health insurance so broadly, and studied as wide a range of consequences. Nevertheless there have been a great many studies, most of them about cost sharing for pharmaceuticals, and they show a fairly clear pattern.

²⁰ Rice and Morrison op. cit., p. 247.

²¹ One good study is Carine Van de Voorde, Eddy Van Doorslaer, and Erik Schokkaert, “Effects of Cost Sharing on Physician Utilization Under Favourable Conditions for Supplier-Induced Demand.” *Health Economics* 10 (2001), 457-471. The authors found no volume response after a system-wide increase in cost-sharing in Belgium. Belgian physicians, however, did not have one option available to many American providers, namely trying to raise prices; and the very high baseline utilization in Belgium may have limited ability to induce more if patients did not come through the door. Evidence about other situations that do not involve cost-sharing does show American providers raising prices of some services when volume of another is reduced; a good example is Uwe Reinhardt, “Perspective: Our Obsessive Quest to Gut the Hospital”. *Health Affairs* 15 (1996), no. 2, 145-154.

²² “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate,” RAND Health Research Highlights, 2006. Accessed at: http://www.rand.org/pubs/research_briefs/RB9174/index1.html. This text and Remler and Greene (2009, 297) both provide good reasons to be cautious about extrapolating results from three decades ago.

First, cost sharing does seem more likely than not to reduce spending. When cost sharing is eliminated by supplemental insurance, both in U.S. Medicare and French national health insurance, that tends to raise total spending.²³ But, second, there are cases in which cost sharing can even raise costs over the long run. This is particularly true if the insured persons have chronic conditions. In essence, higher cost sharing for drugs may lead to lower utilization, so expenses on physician services or hospitalization. A series of RAND studies, for example, “showed that cutting prescription co-payments for patients who needed cholesterol-lowering drugs the most could improve their health and save more than \$1 billion annually in medical costs by increasing adherence and reducing the chance of hospitalization.”²⁴ Discussing a study which found that some enrollees in Medicare drug plans (Part D) stopped taking medications needed to control chronic diseases because of higher cost sharing, Dana Goldman, the study’s senior author and director of health economics at RAND, said “Drug caps are a cost-saving measure, but our findings raise the issue of whether in the long run they may lead to other medical costs such as increased hospitalizations.”²⁵ Similarly, a Canadian study of prescription drug cost sharing found that “when cost sharing for prescription drugs increased, the demand for prescription drugs decreased and the demand for physician visits increased.”²⁶ Amitabh Chandra, Jonathan Gruber, and Robin McKnight found that higher cost sharing for physician services and drugs were associated with greater rates of hospitalization among retired public employees in California. In all such cases, the effects on total costs will depend on the relative prices of reduced services (such as drugs) and extra services (such as hospitalization).²⁷

More generally, studies of cost sharing for pharmaceuticals (which can take many forms) show that it may reduce spending, but may also worsen outcomes, particularly for those with chronic illnesses. Pure outcome measures are rare, but visits to the Emergency Department and hospitalizations, as mentioned in some of the examples above, may be reasonable surrogates for some worsening of health. In some cases patients appear more likely to drop less essential drugs, but the findings are mixed, and include situations in which cost sharing appears to be associated with more hospitalizations and trips to the Emergency Department.²⁸

A 2001 study published in the *Journal of the American Medical Association* looked at the impact of increasing prescription drug cost sharing on use of essential and less essential drugs among

²³ Remler and Greene op. cit. 298; Thomas C. Buchmueller, Agnes Couffinhal, Michel Grignon and Marc Perronin, “Access to Physician Services: Does Supplemental Insurance Matter? Evidence from France.” *Health Economics* 13 (2004): 669-687.

²⁴ “The Health Insurance Experiment,” op. cit., p. 4.

²⁵ “Prescription Spending Caps Cause Some Seniors to Quit Taking Medicines for Chronic Illnesses,” RAND Corporation, September 11, 2007. Accessed at: <http://www.rand.org/news/press/2007/09/11/index.html>

²⁶ Xin Li, Daphne Guh, et al, “The impact of Cost Sharing of Prescription Drug Expenditures on Health Care Utilization by the Elderly: Own- and Cross-Price Elasticities,” *Health Policy*, Volume 82, Issue 3, Pages 340-347, August 2007. Accessed at: [http://www.journals.elsevierhealth.com/periodicals/heap/article/S0168-8510\(06\)00234-X/abstract](http://www.journals.elsevierhealth.com/periodicals/heap/article/S0168-8510(06)00234-X/abstract)

²⁷ Amitabh Chandra, Jonathan Gruber, et al, “Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly,” *Working Paper* 12972, National Bureau Of Economic Research, March 2007, Revised June 2009. Accessed at: <http://econ-www.mit.edu/files/4520>

²⁸ Dana P. Goldman, Geoffrey F. Joyce, and Yuhui Zheng, “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health.” *Journal of the American Medical Association* 298 (July 4, 2007), no.1, 61-69.

elderly persons and welfare recipients in Quebec. The study's authors found that, "increased cost-sharing for prescription drugs in elderly persons and welfare recipients was followed by reductions in use of essential drugs and a higher rate of serious adverse events and ED [emergency department] visits associated with these reductions."²⁹

Cost sharing for emergency-department visits does seem to reduce utilization in appropriate ways.³⁰ This appears to be true even though large numbers of enrollees tend not to know the cost sharing rules for their plans.³¹ That is an exception, however, to the rule. Studies of other services tend to confirm the HIE finding that, faced with higher out-of-pocket charges, patients tend to equally forego "effective" and "ineffective" care.

For example, a study published in the *American Journal of Public Health* on the "Effects of Cost Sharing on Care Seeking and Health Status," found that, "In a chronically ill population, cost sharing reduced the use of care for both minor and serious symptoms."³² There is a particularly strong tendency for cost sharing to reduce consumption of preventive care.³³ A study published in the January 24, 2008 issue of the *New England Journal of Medicine* found that, "(w)hen women in Medicare managed-care plans were asked to contribute a small co-pay, in some cases around \$10 to \$20, 8 percent of the women decided to forgo mammograms altogether."³⁴ "Cross-sectional studies," Remler and Greene report, "confirm the negative relationship between cost-sharing and prevention across a wide range of services, including Pap smears, preventive counseling, clinical breast exams, and self-monitoring of blood glucose for diabetics."³⁵ Other studies show an association between higher cost sharing for behavioral health treatments and reduced levels of useful treatment.³⁶

Overall, the studies published since the HIE confirm that cost sharing in some situations can save money. But they do not confirm the blithe assumption that this will be done in a way that improves value for money. The worries that should have been taken from the RAND study – that cost sharing may have particularly negative effects on sicker and less wealthy people – have been strengthened by subsequent research. As the Kaiser Family Foundation explains: "(a)lthough cost sharing is designed to reduce utilization of unnecessary health care services and

²⁹ "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons," Robyn Tamblyn, Rejean Laprise, et al., *JAMA*, 2001;285:421-429. Accessed at: <http://jama.ama-assn.org/cgi/content/full/285/4/421>

³⁰ *Ibid.* p. 301.

³¹ John Hsu et al, "Cost-Sharing: Patient Knowledge and Effects on Seeking Emergency Department Care." *Medical Care* 42, no. 3 (March 2004), pp. 290-96. Hsu and colleagues have done a series of studies about enrollee knowledge of cost-sharing rules for different services, all with basically the same result.

³² Mitchell D. Wong, MD, PhD, Ronald Andersen, PhD, et al "Effects of Cost Sharing on Care Seeking and Health Status: Results From the Medical Outcomes Study," *American Journal of Public Health*, 2001 November; 91(11): 1889–1894. Accessed at: <http://www.ajph.org/cgi/reprint/91/11/1889.pdf>

³³ Although this is viewed as poor judgment by health policy scholars, perhaps it appears more rational to individuals who believe they must concentrate their resources on present-day problems, because they live closer to the edge than the average health policy scholar.

³⁴ "Co-Pays Contribute to Drop in Preventive Care," *The Washington Post*, By Serena Gordon, January 23, 2008, Accessed at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/01/23/AR2008012302811.html>

³⁵ Remler and Greene op.cit., p. 301.

³⁶ Remler and Greene op. cit, p. 302; in one study they cite, cost-sharing still saves money, but also includes somewhat worse results. Also see "Demand Response of Mental Health Services to Cost Sharing Under Managed Care." Accessed at: http://www.allacademic.com/meta/p_mla_apa_research_citation/0/9/0/5/2/p90526_index.html

increase the cost-consciousness of consumers, it may discourage people from using necessary health care and can be inequitable for the very sick and the low income.”³⁷

If the high-cost health plans were due to particularly generous benefits for healthy people, none of these criticisms would be so important. But what if high costs are associated with greater need for care? Then the excise tax could contradict the whole point of health insurance, and so of health care reform.

The Excise Tax Mistakes Cadillac Prices for Cadillac Benefits

Taxing people with “excessive” health benefits may sound attractive, but the excise tax is a hammer rather than a surgical knife, striking at some costly benefit packages that may be needed and may not be excessive.

Many advocates of the excise tax assume that coverage which costs more than the excise tax threshold is due to very generous benefits. Such plans could, for example, offer free MRIs and spa memberships, at no cost to the individual. In a good summary of the case for the excise tax, Paul Van de Water mentions examples such as the coverage for top executives of Goldman Sachs (which is so generous that it costs \$40,000 per year!), for New Hampshire state employees, and plans received by some teachers.³⁸ Yet, as Van de Water also notes, a particular group of workers might have much higher than average expenses for reasons having little to do with the generosity of their benefits, or the source of the plans.³⁹ For example, coal miners have very expensive health benefits because they are in a very high-risk occupation. According to the United Mine Workers, one of their member companies will pay \$32,469 in health care premiums in 2009 for its pre-retiree workers – the most expensive group to cover. That means they would be subject to the tax, even though they represent a very different type of worker from the Goldman Sachs executives.

Similarly, plans offered by small employers are more likely to be hit with the excise tax. According to Beth Umland, director of research for Mercer, a consulting firm that conducts an annual survey of employee benefits, “About 14 percent of small employers, counted as those with fewer than 500 workers, now offer policies that would be subject to the excise tax. That compares with just 5 percent of large employers with 500 or more workers.”⁴⁰

³⁷ “Cost Sharing for Health Care: France, Germany, and Switzerland,” Kaiser Family Foundation, January 2009. Accessed at: <http://www.kff.org/insurance/upload/7852.pdf>

³⁸ “Excise Tax on Very High-Cost Health Plans Is a Sound Element of Health Reform: Congress Should Retain Tax, But Improve It Further,” Paul N. Van de Water, Center on Budget and Policy Priorities, November 10, 2009, Accessed at: <http://www.cbpp.org/cms/index.cfm?fa=view&id=2957>

³⁹ In spite of unions’ general opposition to the excise tax proposal, union plans cost on average only 4 percent more than the plans that cover nonunion employees. The unions with especially ‘generous’ plans are a distinct exception. “How Does Union Membership Affect Health Insurance Coverage,” Fast Facts, Employee Benefit Research Institute, October 28, 2009, Accessed at: <http://www.ebri.org/pdf/FFE141.28Oct09.Final.pdf>

⁴⁰ “A Proposed Tax on Cadillac Plans May Also Hit the Chevys,” AARP Bulletin, Accessed at: http://bulletin.aarp.org/yourhealth/policy/articles/a_proposed_tax_on_the_cadillac_health_insurance_plans_may_also_hit_the_chevys.html. Very small companies would not be hit by the excise tax, because they would be likely to purchase insurance through the new Exchange mechanisms created in the bills.

Coverage could be unusually expensive, so seem “excessive,” because overhead costs are higher (as for small employers), because the workers have more health problems (as with coal miners), or because they are unfortunate enough to live in an area with high average costs (such as the bigger, more expensive cities). Neither the proponents of the excise tax nor anyone else, when it was first inserted in Senate legislation, had any good evidence about how much of the variation in the costs of coverage is due to benefits, as opposed to how much is due to factors such as the size of the employer, location, and risk-profile of the workforce.⁴¹ At the beginning of December, however, *Health Affairs* released a study that strongly challenges the theory that “Cadillac” costs are due to “Cadillac” benefits.

In an analysis of 2007 survey data, Jon Gabel and colleagues reported that, “It’s often assumed that high-cost health insurance plans—sometimes called “Cadillac” plans—provide rich benefits to plan subscribers. Health reform provisions that treat these plans like luxuries may be misguided. Only 3.7 percent of variation in the cost of family coverage can be explained by benefit design (actuarial value). Benefit design plus plan type (HMO, PPO, POS, or high-deductible plans) explains 6.1 percent of this variation. Industry type and medical costs in the region also play a role. Most variation in premiums, however, remains largely unexplained.”⁴²

This data should not be interpreted to mean that only six percent of the variation in premiums is due to variation in benefit packages. There may be difficulties measuring any of the factors that drive costs. But the new study certainly shows that a large part of variation in costs must stem from other factors.

This is obvious to anyone familiar with the insurance business. As Allan Sloan reports, “as any insurance maven will tell you, costs depend more on the people being covered (old, sick, or both?) and location (high-cost New York or low-cost Montana?) than on the level of benefits. He provides a very appropriate example: the federal government’s Blue Cross standard option would cost twice as much for a group composed of the United States Senate as it does when applied to the federal workforce as a whole.”⁴³

Part of the Senate bill acknowledges this truth, and also helps satisfy some insurance companies, when it allows insurers in the individual or small-group market to charge older workers up to three times as much as younger workers. Insurers vary premiums substantially based on location and occupation as well. In many cases, such as coal miners, **coverage could be expensive simply because the people covered are unusually sick (on average). The vehicle is expensive not because it is a Cadillac—plush seats, really smooth ride, cool sound system, navigational system and other ‘unnecessary’ features—but because it is an ambulance.**

But the Senate excise tax provision acknowledges these issues only in a halting and totally inadequate manner. For example, higher thresholds would apply to select “high-risk” (e.g. the construction, mining, agriculture, forestry and fishing industries) occupations. But these

⁴¹ We say this because we asked one of the advocates for the excise tax whom we greatly respect, and he said he knew of no good data.

⁴² “Taxing Cadillac Health Plans May Produce Chevy Results,” Jon Gabel, Jeremy Pickreign, et.al., *Health Affairs*, January 2010, Accessed at: <http://content.healthaffairs.org/cgi/reprint/hlthaff.2008.0430v1>

⁴³ “‘Cadillac Care’ is largely a myth.” Allan Sloan, *Washington Post*, December 18, 2009, A26.

exceptions for extremely broad occupational classifications bear little relation to the detailed categories used by insurers to set rates. Initially, higher thresholds would apply in the 17 highest-cost states, though these would be eliminated by the end of 2015. This too ignores the fact that health care markets are smaller than states, so that costs can vary greatly within a state. In essence, the Senate bill allows insurance companies to charge more to older workers. But it says that, in applying the excise tax to employer plans, the Internal Revenue Service should not adjust for the age profile of any group of workers. So older workers could take hits from both the insurers and the IRS.

In short, when it is first implemented the excise tax will be unfair and poorly targeted to the supposed problem of “excessive” coverage. Over time, as costs rise more quickly than the threshold for applying the tax, it will become less fair and more poorly targeted.⁴⁴

We should not use taxes to make health care less affordable for low- and moderate-income people who have costly health plans with reasonable benefits. Given the data we do have about the risks that cost sharing will have particularly negative effects on people with greatest health care needs, and the strong reasons to doubt that “Cadillac” prices are due to “Cadillac” benefits, the excise tax seems a particularly dangerous way to reform health care finance.⁴⁵

How to Address “Excessive” Benefits Fairly

It is reasonable to say that we, as a society, want to encourage and in fact guarantee health insurance coverage. Because the proposed legislation offers subsidies for individuals who purchase their own coverage, it is a matter of simple fairness that employees who are covered by their employers receive the benefit of subsidies as well. But it is reasonable to say that any subsidies to help people meet that standard should apply only until a certain standard of coverage is reached. Therefore, it is reasonable to set a standard for the benefits that we as voters want to subsidize indirectly by allowing employers to call those expenses business expenses, so they are not subject to tax.

But the standard should be defined directly: as a standard for benefits, not a standard for costs. Employers should be able to pay for that level of coverage without the premium being taxed as an employee benefit. “Excess” insurance should be defined directly as more than the maximum benefits eligible for subsidy.

⁴⁴ Readers should remember that even the official estimates assume costs will rise more quickly than the standard. That is why CBO estimates revenues from the excise tax will double between 2015 and 2019.

⁴⁵ Careful analyses of the effects of higher cost-sharing emphasize that, for it to have safely positive effects, it would have to vary with beneficiaries’ income and health status, and even with clinical indications for services – so that the cost-sharing for an MRI, for example, would vary by diagnostic indicators. It should be needless to say that it would be very hard to implement such a system of regulated cost-sharing. For such arguments see Chandra et al op. cit; Karen Davis, “Promoting Cost-Effective Care: Consumer Incentives versus ‘Supply-Side Strategy,” (December 3, 2003; accessed at <http://www.hschange.com/CONTENT/632/Davis.ppt>); “The Health Insurance Experiment op. cit; Remler and Greene op. cit.) When other countries have significant cost-sharing, they include special protections targeted on sicker and poorer beneficiaries; for one account see Henry J. Kaiser Foundation, “Cost Sharing for Health Care: France, Germany, and Switzerland,” Menlo Park, CA (January, 2009) downloaded 6 December 2009 from <http://www.kff.org/insurance/upload/7852.pdf>.

Defining “excess” in terms of the actual benefits, rather than costs, would eliminate all the inequities that are risked now and in the future by defining “excess” simply in terms of costs. If a group’s costs are high because of the group’s composition, not its benefits, it would not be penalized. If the tax exclusion were pegged to the benefits, rather than the costs, then if costs per medical condition rose faster than the index factor over time, average citizens who are already being punished with higher employee contributions will not be penalized further for something that is not their fault.

If “excess” is defined in terms of benefits rather than costs, the system will not discriminate against workers with riskier jobs, or who are older, or live in a community with higher medical price levels. The promise of support will be defined in a transparent way, namely we as a society believe this is the proper level of health benefits, instead of the law being written to erode health security over time in an underhanded manner. Goldman Sachs plans may be sanctioned, coal miners’ benefits will not be.

As is true in other countries, the basic social agreement about the level of benefits which we want to guarantee to each other, and the level that people should be expected to pay for out of pocket, will need to have exceptions for the poor. But that is easily done, through supplemental coverage for people who cannot afford even a modest level of cost sharing, as is already included in the legislation for insurance purchased on the individual and small-group markets. Congressional advocates of the excise tax should tell us what level of coverage is appropriate and defend that argument. No nation provides government subsidies for all possible health care, and the U.S. should not do so. But the excise tax mechanism is an extremely flawed way of defining the social guarantee of benefits. An excise tax designed to lower the social guarantee over time in hopes the public will not notice is even worse.

Policy Alternatives for Cost Control and Equity

If the goal of the excise tax is to finance coverage of the uninsured in a progressive manner, so by raising more money, proportionally, from people with higher incomes, the “Cadillac” tax is a particularly poor way of achieving that goal, because it will in fact raise taxes for many middle- or even lower-income employees. Higher income taxes only for wealthy Americans, as the House bill proposes, would be a much more effective way to collect from them to pay for expanding insurance to less fortunate Americans. Higher payroll taxes on higher-income wage earners, as in the Senate draft, would also be far more progressive.

The regressivity issue

Ironically, advocates of reducing the tax deductibility of health insurance benefits commonly argue that the current system is regressive, so that reducing the deduction, as through the cap, would be progressive. This argument is a bit confused. It starts from the observation that, if you have a higher income, your marginal tax rate is higher. Therefore, the tax savings from buying \$13,000 in health insurance with pre-tax dollars are greater for people with higher incomes than people with lower incomes, making the subsidy “regressive.”

The flaw in this argument is that it overlooks the fact that health care benefits are a much larger part of total income for lower-income workers than for higher-income workers. Therefore, eliminating some portion of the subsidy affects more of the income of lower-wage workers, and this income-share affect tends to overwhelm the tax rate effect. In data derived from tax rates and insurance plans in 2004, for example, Urban Institute analysts found that the tax deductibility of health insurance averaged 5.8% of after-tax income for people with incomes between \$30,000 and \$40,000, but only 3.2% for individuals with incomes between \$100,000 and \$200,000, and only 1 percent of income for individuals with incomes above \$200,000. As Cathy Schoen and colleagues conclude in a recent report from the Commonwealth Fund, **“the current exemption represents a larger tax break as a percentage of income for low-income households with employer coverage and a smaller tax break for higher-income households.”** (Our emphasis) By the normal standards by which the progressivity or regressivity of taxes is judged – namely the proportion of income taken in taxes – the tax exclusion does not make the tax system less progressive – for people who have coverage. The real inequity is between the people who have benefits and those who do not.⁴⁶

Calls for eliminating the tax exclusion and employer role entirely

We are not arguing that the exclusion of health care premium costs from taxation is an ideal way for the government to finance medical care. **We understand that the major reason why some distinguished economists with whom we have discussed the excise tax endorse the tax is that they see it as a step towards eliminating the employer role in health insurance.** They feel that direct government subsidies for individuals to purchase insurance would be more efficient and targeted more effectively on need. From this perspective, cutting back the tax subsidy for the most expensive plans is a modest compromise, and a step in the direction of moving employers out of the health insurance business.

The problem with this argument is, even if one agrees with the goal, the rest of both the House and Senate bills is designed to try to preserve the employer role.⁴⁷ Therefore, in the bills as written, participation in the exchanges is limited to smaller employers. Larger employers would be forced to pay penalties if they stop providing insurance. So the excise tax would penalize employers if they sponsor insurance for less healthy groups in more expensive areas; but then the bills would penalize them if they did not sponsor insurance. If employers choose to avoid both penalties, then the effect of the excise tax will be to target reductions of the tax exclusion on the groups that need some subsidy most – without offering them a direct alternative.⁴⁸ We do not

⁴⁶ Cathy Schoen, Kristof Stremikis, Sara Collins and Karen Davis, “Progressive or Regressive? A Second Look at the Tax Exemption for Employer-Sponsored Health Insurance Premiums,” Commonwealth Fund Issue Brief (May 2009).

⁴⁷ There are two powerful political reasons to preserve the employer role: voters do not want to be forced out of their current arrangements, and more people in the exchanges would mean more direct subsidies and “bigger government.” There is one strong substantive reason that the bills have not attempted to eliminate the employer role as intermediaries in the insurance market: nobody knows how to ensure that the money currently going from wage pools towards benefits still flows to the same people in the same amounts. So the transition could require substantial extra government revenues of some other sort, plus create new inequities.

⁴⁸ If you view the exclusion of medical expenses from taxation as a government subsidy to help people purchase insurance through their employers; and if more expensive plans are largely due to more expensive groups, then the larger subsidy to more expensive plans is actually appropriate. This is exactly the opposite of Jon Gruber’s conclusion in “‘Cadillac’ tax isn’t a tax” op.cit. The reality depends entirely on the reasons some plans are more

see how this serves the goal, which we believe we share with some of the economists who champion the excise tax, of increasing equity.

Without evidence that particularly expensive plans are concentrated on particularly high-income workers, there is no reason to believe that the excise tax will make the tax code fairer. But the debate over the excise tax proposal involves another issue that is as fundamental as its likely effects on equity and health outcomes. It involves whether the best approach to cost control is to address the economic demand for care, or other influences upon costs.

Many U.S. health policy analysts are fixated on utilization. As Bruce Vladeck and Thomas Rice explain, this fixation lacks face validity. “We do not dispute that higher patient cost sharing reduces service usage. But lower utilization in the United States has done nothing to reduce costs (see Exhibit 1). The United States spends more than 50 percent more than the second-highest country, Switzerland, and nearly twice the amount of many others, but it is tied for the lowest hospital usage rates and ranks eighth of ten in use of physician services.⁴⁹

EXHIBIT 1
Bed Days, Physician Consultations, And Spending Per Person In Selected Countries, Various Years

Country	Acute care bed days per capita	MD consultations per capita	Per capita spending (US\$)
Australia	1.0	6.1	\$2,999
Canada	0.9	5.9	3,460
France	1.0	6.4	3,306
Germany	1.7	7.0	3,251
Japan	2.0	13.7	2,474
Netherlands	0.7	5.6	3,192
Sweden	– ^a	2.8	3,012
Switzerland	1.1	3.4	4,069
United Kingdom	0.9	5.1	2,580
United States	0.7	4.0	6,347

SOURCE: Organization for Economic Cooperation and Development. OECD health data 2008: statistics and indicators for 30 countries. Paris: OECD; 2008.

NOTES: Data are the most recent available. Acute care bed days: 2005 or 2006. Physician consultations: 2004–2006, except Switzerland (2002). Spending per capita: 2005.

^aData not available.

Theodore Marmor, Professor Emeritus of Public Policy and Management & Professor Emeritus of Political Science at Yale University, explains how the focus on reducing demand, on the assumption it will reduce utilization, applies to the excise tax debate. “The assumption from

expensive than others. We might change our position if the balance of the evidence did not suggest, counter to the rhetoric, that “Cadillac” plans do not generally have “Cadillac” benefits.

⁴⁹ Bruce C. Vladeck and Thomas Rice, “Market Failure And The Failure Of Discourse: Facing Up To The Power Of Sellers: The United States won’t make headway on costs without strengthening payers’ hands,” *Health Affairs*, September/October 2009, Accessed at: <http://content.healthaffairs.org/cgi/content/abstract/28/5/1305> For further evidence supporting their argument, see Jonathan Oberlander and Joseph White, “Public Attitudes Toward Health Care Spending Aren’t The Problem: Prices Are,” *Health Affairs* 28:5, 2009,1285-1293.

which this [support for the excise tax] proceeds,” he writes, is that we should be critical—even contemptuous—of the wish for first-dollar, extensive health insurance. Why else use the slogan, Cadillac coverage, when the proper description is broad coverage of health risks with no deductibles or co-insurance to speak of? Yet our Canadian neighbors have precisely that coverage for hospital and physician services and spend roughly 40 percent less per capita while using more physician visits and bed days than do American patients.”⁵⁰

Policy-makers in other countries do use cost sharing to reduce economic demand, but in limited and focused ways. It is not the core of their cost-control measures, precisely because of concerns that it will reduce the wrong care.⁵¹ Other countries have lower costs than the U.S., in spite of the fact that they have more extensive insurance, because they have stronger policies to control some of the input costs of and incomes created by medical care. They regulate the fees and budgets paid to medical providers, limit the entrepreneurial competition that leads to excessive purchase and inefficient use of medical equipment, and have lower administrative costs because of their far simpler insurance systems and payment systems, which reduce overhead both for insurance and health care services.⁵² They also generally exempt the poor and chronically ill from cost sharing obligations.

The House and Senate bills either fail to include these reforms or do not go far enough in applying them to the entire health care and health insurance system, rather than just to Medicare and Medicaid. While it may be politically expedient for Congress not to take on the special interests through these means, at the end of the day these approaches offer far greater prospects for reining in costs and improving care in America than anyone should expect from taxing “excessive” benefits. The fact that the definition of excessive benefits in the excise tax proposal is faulty just makes that approach less equitable, as well as less effective.

Although the excise tax appears to be an attempt by legislators to avoid the political risks of proposing more effective and equitable cost controls, one final argument for the excise tax claims that it will motivate employers and insurers to make greater efforts to control costs.

Critics of the tax deductibility of healthcare coverage argue that this subsidy causes both employers and employees to care less than they should about healthcare costs. “This tax break,” New York Times columnist David Leonhardt writes, “causes us to buy more health insurance than we would if the playing field for taxes were level, much as the tax breaks for housing helped inflate the real estate bubble. In effect, the tax-free treatment is a subsidy for health insurers, doctors, and hospitals. It encourages wasteful spending...” According to this theory, if one can buy \$15,000 of health insurance with pre-tax dollars – so it “only” costs, say, \$11,000 in post-tax dollars -- the \$11,000, and the six or eight or ten percent increase in that amount each year will not seem like so much money. Therefore the purchaser won’t try so hard to reduce the cost. Many advocates of the excise tax whom we know prefer to eliminate tax deductibility

⁵⁰ Personal communication.

⁵¹ “AARP European Leadership Study: European Experiences with Health Care Cost Containment: France, the Netherlands, Norway, and the United Kingdom,” AARP, October 2006. Accessed at: http://assets.aarp.org/www.aarp.org/_cs/gap/ldrstudy_costcontain.pdf

⁵² For more detailed discussion see Oberlander and White op. cit., and Joseph White, “Cost Control and Health Care Reform: The Case for All-Payer Regulation.” Health care reform discussion paper, posted to the Campaign for America’s Future website, May 2009. Accessed at <http://www.ourfuture.org/files/JWhiteAllPayerCostControl.pdf>

entirely, so the amount of insurance purchased will not be “distorted” by the tax code hiding its true cost. But they at least hope the excise tax will start “to eat away at this tax break.”⁵³

We do not recognize the world that this theory describes. In fact, the literature about the health insurance industry, and simple observation, show that employers continually shop and bargain, changing their benefit packages and complaining about costs, while insurers craft plans to meet employer concerns about costs (not very well, however). We have to wonder why employers, which are assumed to seek continually to minimize input costs and maximize margins, and so to shop for lower prices for all inputs, would not already do so for this particular major cost – which, on their books, is a business expense like any other.

We also have to wonder how, even if employers cared more about costs, this would enable them to impose better prices and utilization management on the medical world. Would caring more give employers and insurers more bargaining power against dominant local hospitals and specialty groups? Why? Would it lead to new innovations in efficient delivery systems? How? Would it make it easier to generate evidence that could be used to regulate care? Anyone who thinks so must have missed the recent controversy about mammograms. The cause and effect connection between the tax treatment of insurance and the delivery of and payment for medical care is long and tenuous. It requires heroic assumptions to conclude either that employers have not been caring “enough” given the tax exclusion or that, even if they cared more, they could do much about it just because the tax code changed.

What employers lack is not interest in controlling costs. They lack the power to control costs. There is no other advanced industrial democracy in which isolated employers are expected to get good deals from powerful insurance and medical industries. In all other countries, even those in which employers have a major role in health insurance, the government organizes the payer side of medical care negotiations to create the power needed to control costs. Mercedes Benz in Germany and Honda in Japan and Fiat in Italy do not pay less for health care than the automobile companies pay in the U.S. because the U.S. tax system makes automobile companies not care about costs in the U.S. Ford does not pay less for health care in Canada than it does in the U.S. because Ford’s Canadian executives care more about costs than Ford’s U.S. managers do. Health care costs more in the U.S. not because the payers don’t care, but because public policy does not help them control costs.

The argument for savings from the excise tax reduces to two propositions. One says that higher cost sharing will provide “harmless” cost control. This goes far beyond what can be supported from the available evidence. The other is that, because of the current tax break for insurance, employers and employees have not cared enough about controlling costs, and if they were forced to care more, they would be more successful. This is a remarkable leap of faith about power relations in medical care markets, and their consequences.

There are much better ways to make health care finance more equitable and efficient. The excise tax is extremely risky, based on questionable evidence, and very poorly designed for any appropriate policy goals.

⁵³ David Leonhardt, “Economic Scene: How a Tax Can Cut Health Costs.” *New York Times* (Sept 30, 2009).