ONE OF FEW THINGS GROWING AS FAST AS HEALTH CARE COSTS IS INCOME OF RICHEST 1%

The Economic Policy Institute provides a much needed counter-weight to those cheerleading the use of Cadillac-as-Chevy taxes to pay for the Senate health care bill. It shows, generally, that the millionaire's tax used to fund the House bill is far more progressive than the Cadillac-as-Chevy tax used to fund the Senate bill, which ends up taxing those at $20-30,000 more than it taxes those at $500,000 to 1 million a year.

In fact, it makes an even more striking point. Given the way the economy has worked in the last several decades, one of the few ways to fund health care in such a way that will keep up with rising health care costs is to tax the rich.

> While a funding source that grows with health care costs is a desirable goal, it should be noted that for the last three decades one of the only things in the American economy that actually has grown as fast as overall health costs is the incomes of the richest 1% of households.

The paper points out two central reasons why the excise tax won't be as progressive as its champions claim.

Most importantly, it shows that the cost of a plan does not reflect exclusively on how generous the benefits of that plan are. On the contrary, plan cost has more to do with group size and overall health than it does with the benefits granted.

> The assumption that high-cost plans are high-value plans is flawed. Many health

> plans are expensive because the population covered is older or sicker than average, but they still do not provide more comprehensive coverage. Moreover, this is a much larger problem than is often recognized. Gould and Minicozzi (2009) have shown that some of the most powerful predictors of a plan's high cost are the size of the firm and the age of its workers. This is surely not a coincidence—small firms and firms with older workforces tend to have less bargaining power with insurance companies and this leads to higher prices for insurance coverage that may be no more comprehensive than lower-priced coverage for larger or younger firms. It should be noted that the Senate bill recognizes this reality and specifically exempts some health plans (those covering high-risk professions, for example) from the excise tax or raises the threshold of the tax explicitly on the grounds that high-cost is not synonymous with high-value.
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> Furthermore, Gabel et al. (2010) find that only 3.7% of the variation in premiums for family plans is determined by a plan's actuarial value, that is, the share of average medical expenditures paid for by insurance (instead of by outof-pocket spending). It is also worth noting that the Joint Committee on Taxation's (JCT) scoring of the excise tax indicates that plans with fewer enrollees are more likely to be affected by the excise tax. Given that previous research has shown that smaller firms pay premiums 18% higher than large firms pay for equivalent health coverage, it seems clear that **this excise tax will be affecting many workers who have only high-cost—not high-value—health coverage** (see Gabel et al. (2006)). [my emphasis]

So workers at smaller firms and those with sick co-workers will be asked to pay for the health care reform, not primarily a bunch of Goldman execs who have luxurious benefits.

In addition, the EPI paper gives a host of reasons why it is actually doesn't save money to have people forgo care to save money. Basically, for a whole host of expensive, chronic diseases, the overall cost of treatment will be lowest if patients actually use health care to manage their condition.

> If the excise tax pressures people to purchase health plans with increased cost-sharing (e.g., higher copayments), consumers may very well respond to this effective price increase by haphazardly cutting back on medical spending. However, many of the interventions that are avoided may turn out to be health-improving and/or cost-effective. This problem is especially true for vulnerable populations. Research has demonstrated that low-income and chronically ill populations are generally harmed by higher cost-sharing and may actually incur higher overall costs in response to the introduction of this cost-sharing, as they cut back too much on cost-effective managing of chronic conditions.
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> Research has found that the optimal cost-sharing rate for many chronic conditions and large classes of prescription drugs is very low or even zero. This same research shows that increased cost sharing in certain areas (e.g., prescription drugs or primary care) can lead to higher overall costs due to increased utilization in other areas (e.g., hospitalization).

That is, if we force chronically ill people to pay more of their treatment costs out of their own pocket, society will spend more on their

treatment overall.

I just have one complaint about the paper. It treats seriously the claim that if a company saves money on health care, it will pass on those savings—in the form of higher wages—to employees. Such claims are based on studies that show that when health care cost increases, employers respond by lowering wages. Aside from the fact that no one is envisioning employers paying less than they currently do for health care (but instead, of adjusting plans to keep costs about the same), this argument relies on a logical flaw—the assumption that the reverse holds true too, that employers will pass on savings to employees. Maybe there's a study that proves that this is the case, but thus far the only thing studies show is that by raising the cost of health care—which the excise tax will do—it will lead to job losses.

But the EPI study makes a really critical point. The argument for funding health care reform through a Cadillac-as-Chevy tax is an attempt to avoid the so-called class warfare that singles out the really rich and asks them to contribute back to society. But when you consider the fact that the salary of the really rich is rising as fast as health care costs, it seems to make more sense to have the rapacious rich pay for the the rapacious costs of health care. 3