

VIEWPOINT

Katherine Baicker, PhD

Harvard School of Public Health, Boston, Massachusetts.

Amitabh Chandra, PhD

Harvard Kennedy School, Boston, Massachusetts.

The Veiled Economics of Employee Cost Sharing

This year, once again, millions of people in the United States who get health insurance through their employers received the unwelcome news that cost sharing would increase. Harvard University, where both of us work and get our health insurance, increased cost-sharing for its employees, raising a hue and cry from faculty.¹ There were charges that the changes were regressive and particularly harmful for lower-wage employees.¹ The critiques implicitly presumed that it is possible to have high wages, lower premiums, and no cost sharing. But this presumption misses the fundamental economic connections between wages, premiums, and cost sharing.

Cost sharing has certainly increased, from copayments for physician office visits and prescription drugs to deductibles; the fraction of workers in a plan with at least a \$1000 deductible for coverage of a single person increased from 10% in 2006 to 41% in 2014.² Higher cost sharing feels like a decrease both in the generosity of coverage and in compensation. It seems particularly unfair to lower-wage workers who face the same deductibles and copayments as their higher-paid counterparts and who may be discouraged from seeking needed care. But increases in cost sharing are not necessarily regressive nor necessarily associated with lower compensation.

The reality of who actually pays for health insurance drives the different impacts of changes in insurance plans on low-wage and high-wage employees. Despite the hand-wringing over increases in employee premium contributions, the employee share of premiums has stayed between 27% and 29% for the last 2 decades, although the dollar amounts have increased because total premiums have increased. The premium for a family policy more than doubled from approximately \$8000 in 2002 to \$16 800 in 2014.² This is far from transparent to employees, most of whom do not see their employer's share of the premium. More important—but even more opaque—is the fact that employees ultimately pay not only their share of premiums but their employer's share as well.³ This is driven by the economics of labor markets. Employers are largely indifferent between paying an employee \$40 000 in wages and \$20 000 in benefits and paying \$50 000 in wages and \$10 000 in benefits—in both cases, total compensation is \$60 000. When the cost of health insurance increases, less money is left available for wages. This "wage-fringe" trade-off is well documented and applies to nonprofit and for-profit employers alike. Increases in health insurance premiums do not get absorbed by an unlimited reservoir of profits or endowments—they are paid for by employees taking home smaller paychecks.^{4,5} The trade-off does not occur instantaneously for each individual, however. So increases in premiums are much more visible and salient than their effect on take-home pay.

The trade-off between wages and fringe benefits is central to understanding the distributional effects of increases in health care costs. Employers provide a similar menu of insurance options to workers with different wages and salaries. Health insurance premiums represent a much larger share of compensation for a family taking home \$40 000 than for a family that makes \$150 000—and a premium increase of \$1000 takes a much bigger percentage bite out of take-home pay for the lower-income family. A lower-income family might prefer to have less generous health insurance and more compensation, so that more money was available for rent, gas, and other priorities. So why do they have this compensation package?

A key reason that employers provide a similar menu of insurance options, regardless of an employee's income, is that the tax code in the United States favors health insurance benefits relative to wages as long as employers offer their high- and low-wage workers the same plans. This tax preference fosters compensation packages that are skewed toward health insurance rather than wages. The skewing has 2 insidious effects: it is both regressive and inefficient.

The tax preference for health insurance is regressive because it gives a greater tax benefit to higher-income workers: an employee in the 40% marginal tax bracket with a \$10 000 tax-free policy saves \$4000 in taxes avoided, whereas an employee in the 15% tax bracket saves only \$1500. Higher-income workers are also more likely to have jobs that offer expensive insurance plans. As a result, lower-wage workers have slow or nonexistent wage growth because of the growing share of their compensation devoted to health insurance instead of wages, and their insurance plans cater more to the preferences of higher-wage workers than to theirs. Remedying this regressive aspect of the tax code is one of the motivations for the "Cadillac tax": starting in 2018, health insurers have to pay a tax on employer health insurance plans with premiums greater than \$10 200 for individuals or \$27 500 for families.⁶ These dollar amounts increase only as quickly as inflation, so if health insurance premiums increase more quickly, more and more plans will be subject to the tax over time. The Cadillac tax provides a motivation for employers to slow premium growth.

Another reason to reduce the tax subsidy for expensive employer-sponsored health insurance is that the subsidies encourage the proliferation of plans with minimal cost sharing, which in turn encourages the inefficient use of medical care. At first blush, it might seem that cost sharing is just a way of dividing up whether employers or employees pay the bills, but decades of evidence show that lower cost sharing leads patients to consume more care of limited health value—such as unnecessary tests—and that this consumption leads to higher health insurance

Corresponding

Author: Katherine Baicker, PhD, Harvard School of Public Health, 677 Huntington Ave, Kresge 401, Boston, MA 02115 (kbaicker@hsph.harvard.edu).

premiums.^{7,8} Cost sharing can thus mitigate the premium increases that would be needed to expand coverage to new services—many of which may particularly benefit patients with serious illnesses.

The potential usefulness of cost sharing does not, however, mean that we would all be better off with across-the-board increases in cost sharing.⁹ First, insurance provides crucial financial protection against potentially catastrophically high health expenditures. Patient cost sharing erodes the value of the risk protection that health insurance provides. The benefit of reducing the overuse of medical services that is inherent in subsidizing health care must be balanced against the cost of losing financial protection when it really matters. A disproportionate share of health spending is for a relatively small number of people requiring very expensive care. Any insurance plan with adequate protection against catastrophic out-of-pocket spending (such as an annual out-of-pocket maximum of \$10 000) will leave a substantial share of health care expenditures in excess of that maximum, and thus not subject to cost sharing. Second, as we have discussed, a given dollar amount of cost sharing has different implications for people with different incomes, suggest-

ing that optimal cost sharing might increase with income. At present, this feature is seen more in cost-sharing subsidies for low-income enrollees in some public plans than in employer-sponsored health insurance. Third, patients facing higher deductibles and copays may reduce care of high value (such as adherence to effective medications) along with the care of low value (such as tests that are not recommended).^{8,10} The evidence suggests that more sophisticated cost sharing, such as higher copays for care of questionable health benefit, might encourage higher-value health care spending and stem the growth of health insurance premiums. Examples are “carve-outs” that protect preventive care from copayments and “value-based” insurance plans that subsidize medications that help keep patients out of the hospital.¹⁰

These caveats do not mean that cost sharing should be eschewed as a tool to improve value—but rather that cost sharing should be deployed in a more nuanced way than it is now. If enabled by regulatory changes and health care system reforms, cost sharing based on the value of care and scaled by income could improve health, slow increases in health insurance premiums, and increase take-home pay.

ARTICLE INFORMATION

Published Online: May 4, 2015.

doi:10.1001/jamainternmed.2015.1109.

Conflict of Interest Disclosures: Dr Baicker is a Commissioner on the Medicare Payment Advisory Commission and is a Director of Eli Lilly. Dr Chandra is the Chief Scientific Officer for Precision Health Economics. Drs Baicker and Chandra both serve on the Congressional Budget Office’s Panel of Health Advisers. No other disclosures are reported.

REFERENCES

1. Pear R. Harvard ideas on health care hit home, hard. *New York Times*. January 5, 2015. <http://www.nytimes.com/2015/01/06/us/health-care-fixes-backed-by-harvards-experts-now-roil-its-faculty.html>. Accessed March 20, 2015.
2. Kaiser Family Foundation; Health Research and Educational Trust. *Employer Health Benefits 2014 Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation and Chicago, IL: Health Research and Educational Trust; 2014. <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>. Accessed March 20, 2015.
3. Baicker K, Chandra A. Myths and misconceptions about US health insurance. *Health Aff (Millwood)*. 2008;27(6):w533-w543.
4. Baicker K, Chandra A. The labor market effects of rising health insurance premiums. *J Labor Econ*. 2006;24(3):609-634.
5. Currie J, Madrian B. Health, health insurance and the labor market. In: Ashenfelter O, Card D, eds. *Handbook of Labor Economics*. Amsterdam, Netherlands: Elsevier Science; 2000:3309-3416.
6. Patient Protection and Affordable Care Act, HR 3590, 111th Cong, 2nd Sess (2010).
7. Chandra A, Gruber J, McKnight R. Patient cost-sharing and hospitalization offsets in the elderly. *Am Econ Rev*. 2010;100(1):193-213.
8. Baicker K, Goldman D. Patient cost-sharing and healthcare spending growth. *J Econ Perspect*. 2011;25(2):47-68.
9. Baicker K, Levy H. Cost sharing as a tool to drive higher-value care. *JAMA Intern Med*. 2015;175(3):399-400.
10. Cherner ME, Juster IA, Shah M, et al. Evidence that value-based insurance can be effective. *Health Aff (Millwood)*. 2010;29(3):530-536.