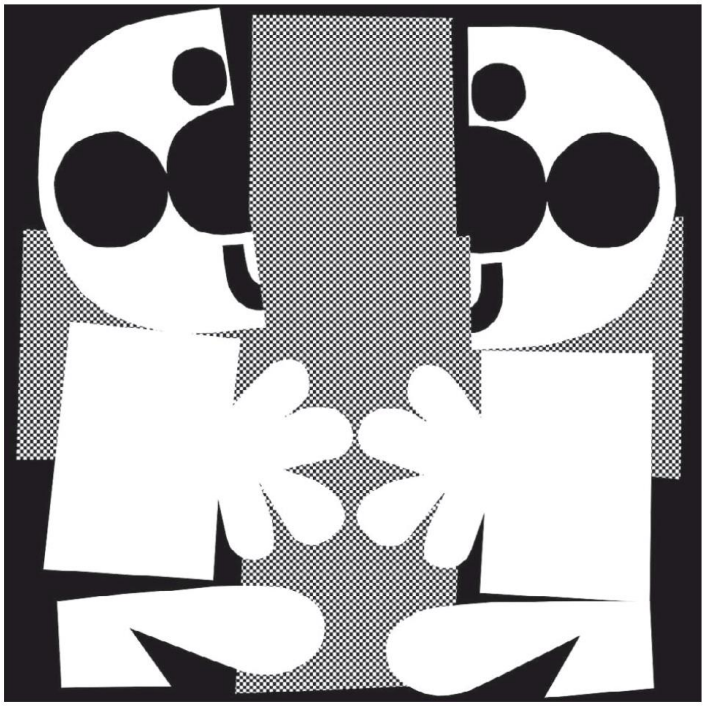
TheUpshot

One-Size-Fits-All Insurance Hurts Low-Wage Workers

By NICHOLAS BAGLEY and AUSTIN FRAKT



ADAM HIGTON

A co-worker struggling to make ends meet comes to you with a problem. The price of admission to a dear colleague's retirement party at an upscale establishment is beyond her means, though not yours.

You both feel obliged to attend. She'd rather bring some refreshments to a conference room than spend what she cannot afford on a lavish event. You like the idea of a grand send-off for your retiring colleague. There can be only one party.

A similar, underrecognized conundrum arises in health insurance. Both you and your less fortunate co-worker are obliged under the law to obtain coverage (which you both want anyway).

But you differ in what you'd prefer to pay for. A high-level manager who makes, say, $200,000 per year is probably willing and able to pay more for health care than someone who makes $50,000.

Unfortunately, neither person really has a choice because the plans all cover "medically necessary" care, meaning any care that offers a clinical benefit. That includes lots of expensive and technologically sophisticated care that is no better, or only slightly better, than cheaper alternatives. You may be just fine with paying for high-tech care of marginal value. For your colleague of more modest means, it's a stretch.

Consider, for example, treating prostate cancer with proton-beam therapy. It's more expensive than alternatives like intensity-modulated radiation therapy, but isn't proven to be any better. If given the choice, many people — especially those with lower incomes — might rather buy health insurance plans that exclude high-cost, low-value treatments.

The trouble is that insurers rarely sell those sorts of plans. Even insurers that try to exclude a particularly expensive and unproven technology from coverage are often rebuffed by legislatures and the courts.

This one-size-fits-all approach to insurance coverage disproportionately hurts low-income people, many of whom might reasonably prefer to devote their scarce dollars to housing or their children's education. To some extent, subsidies and other monetary adjustments can mitigate this problem. Medicare and Medicaid, for example, are financed in large part out of federal income taxes. And within the Affordable Care Act marketplaces, lower-income people receive subsidies that cover some of their costs.

People who receive coverage through their employers, however, don't get that kind of help.

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Perversely, employer-sponsored health insurance is more highly subsidized for the rich than the poor. The subsidy comes in the form of an exclusion of health-insurance premiums from taxation. Since income tax rates are progressive — that is, the rich pay a higher rate of income tax than the poor — lower-income families get less of a benefit.

But both high-wage and low-wage workers at the same company are effectively forced into the same plans. To qualify for the tax exclusion, federal law requires that companies offer the same plans to all or most of their employees, with no consideration for the variable demand for health care. Employees then pay for their fringe benefits by taking home lower wages — and a flat, across-the-board cut in wages burdens low-wage workers disproportionately.

In theory, the labor market could adjust in ways that might lessen the problem: Low-income workers, for example, could demand higher wages for being forced into plans that are more expensive than they'd prefer. These would have to be made up by reducing the wages of high-income workers, something it's not clear they would accept. There's no evidence that labor markets actually work this way.

"The notion that labor markets perfectly offset the varying preferences for health insurance among workers by giving higher wages to those who value health insurance less is a comforting but crazy idea," said Amitabh Chandra, a Harvard economist.

The problems with one-size-fits-all insurance run deeper. In some insurance markets, like those for small businesses in Massachusetts, employees across companies are pooled together and pay the same premium. A recent report from the Massachusetts attorney general showed that workers in companies that receive health care at less expensive hospitals effectively subsidize those at comparable companies who receive care at more expensive ones.

The uniformity of insurance plans also affects the pace and composition of technological innovation. To extend our party metaphor, if everyone — even those who preferred simpler events — were effectively forced to pay for any retirement party, regardless of how lavish, we'd see, and pay for, retirement parties of ever-escalating extravagance.

In much the same way, medical innovators respond to the size of the market for new technologies. The fact that health plans routinely cover all medically necessary care sends an "if you build it, we will pay for it" signal. Innovators are not getting the right signals, the right incentives, to develop high-value or cost-saving treatments. It's more lucrative, instead, to develop pricey new therapies, even if they offer only marginal clinical benefits. The result is lots of new treatments that don't provide much bang for the buck.

Those new treatments pose a continuing challenge to efforts to bend the cost curve. Economists have long known that technology is the primary driver of escalating health expenditures. Indeed, in 2012 medical technologies that were not offered a decade earlier accounted for almost a third of Medicare spending delivered by physicians and outpatient hospital departments.

What's to be done? Managing technological innovation would require us to consider policy changes that would have been unthinkable a generation ago. "The tax code could be restructured to make extravagant health insurance less appealing," Mr. Chandra suggested. Employers might then offer health plans that appealed more to low-income workers.

The Cadillac tax on expensive health plans, which is scheduled to go into effect in 2020, is a step in that direction but doesn't go far enough, according to Mr. Chandra. And it is unpopular across the political spectrum. Other ideas — like incorporating cost-effectiveness criteria into Medicare and private plan coverage criteria — are sure to prompt disagreement.

Contentious solutions they may be. But as the cost of health care and health insurance rises, it won't be a party for politicians feeling more pressure from consumers.

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