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Recommended Citation

Gamage, David and Shanske, Darien, "Using Taxes to Support Multiple Health Insurance Risk Pools" (2017). *Articles by Maurer Faculty*. 2638.

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ACADEMIC PERSPECTIVES ON SALT

state tax notes®

Using Taxes to Support Multiple Health Insurance Risk Pools

by David Gamage and Darien Shanske



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In this edition of *Academic Perspectives on SALT*, the authors discuss Republican U.S. Sen. Ted Cruz's recent health insurance deregulation proposal. They explain concerns about the proposal and offer suggestions for how states could continue to insure their most vulnerable residents should the Cruz proposal be enacted as part of healthcare reform.

As we write, healthcare reform has been declared dead – and risen from the dead – so many times that we have run out of zombie metaphors. We simply have no idea where we will be in the process when this article is published. We will nevertheless address a reform proposal advanced by U.S. Sen. Ted Cruz, R-Texas, because that proposal raises some fundamental questions about the nature of health insurance regulation in the United States. As has been widely reported, Cruz has been

pushing a new health insurance deregulation proposal.¹ If enacted, Cruz's proposal would "allow insurers to sell individual-market plans that don't meet the [Affordable Care Act's] popular consumer protections – as long as they offer at least one plan in the same market that complies with those mandates."²

The proposal raises fundamental questions about the nature of health insurance regulation in the United States. In most markets, it is considered desirable for consumers to have more choices. Other areas of law and regulation – such as antitrust law – are largely motivated by the goals of promoting choice and competition. But health insurance regulation is different.

The ACA prevents health insurance providers from denying coverage or charging more to those with preexisting health conditions. The health reform legislation that was recently passed by the House of Representatives – the American Health Care Act (AHCA) – would maintain those provisions.³ The version of that legislation that the Senate has been considering – the Better Care Reconciliation Act (BCRA) – would likewise maintain those provisions.⁴

Cruz's proposal is different in that it would allow insurance providers to offer plans that deny

¹ See Harris Meyer, "Cruz Insurance Proposal Underscores Trouble With Protecting Pre-Existing Conditions," *Modern Healthcare* (June 30, 2017).

² *Id.*

³ For our prior essays analyzing the AHCA, see David Gamage and Darien Shanske, "The American Health Care Act Would Toss the States a Hot Potato," *State Tax Notes*, May 8, 2017, p. 579; and Gamage and Shanske, "How States Can Respond to the AHCA: Using the McCarran-Ferguson Act," *State Tax Notes*, July 24, 2017, p. 367.

⁴ For discussion, see Margot Sanger-Katz, "Ted Cruz Has an Idea for How to Cover High-Risk Patients," *The New York Times*, July 5, 2017.

coverage or charge more to those with preexisting health conditions — so long as each provider offered at least one other plan that didn't contain those limitations.

It has long been understood by economists and by other healthcare experts that simply preventing insurance providers from denying coverage or charging more to those with preexisting health conditions can create adverse-selection death spirals for the insurers.⁵ The danger is that healthier people might choose to purchase health insurance plans that provide better everyday benefits but worse coverage for expensive health conditions. Alternatively, healthier people might choose to forgo purchasing health insurance altogether.

Either way, that would leave insurance plans that offer good coverage for expensive health conditions with a sicker and more costly pool of insureds. To compensate, those plans would need to raise prices for all insureds,⁶ but that would further drive away healthier people, making the remaining pool of insureds even sicker and costlier, leading to further price increases, and so on.

In other words, giving consumers more choices when it comes to health insurance can result in the market collapsing — leaving the sickest and most needy consumers without any good choices.⁷ It should come as no surprise then that Cruz's proposal has been widely criticized for threatening health insurance risk pools. By giving healthier consumers the choice of purchasing plans that are better for them — at least so long as they remain healthy — Cruz's plan would threaten to undermine the coverage options available to sicker consumers.

That Cruz's proposal would require health insurers to offer at least one plan that complies with the ACA's consumer protections is of little

help in that regard. Because healthier people could be expected to opt for the noncompliant plans, the pool of insureds interested in purchasing the compliant plans would become far sicker and costlier, resulting in insurance providers charging high prices for those plans.

By contrast, under the ACA, the healthcare exchanges were designed around maintaining a single exchange-based risk pool. Of course, employer-sponsored insurance plans were understood to be outside that single exchange-based risk pool because employer populations were thought to be sustainable risk pools of their own, at least for large employers. But the ACA's marketplace regulations were designed to prevent non-employer plans from undermining the single exchange-based risk pool. Again, Cruz's plan would threaten that regulatory framework.

One problem with how the ACA's regulations maintain the single exchange-based risk pool is that in doing so, those regulations limit the potentially positive aspects of consumer choice and provider competition.⁸ That is because health insurance providers have limited ability to design innovative new policies that might be more attractive overall, because those providers must comply with the ACA's regulations that are meant to prevent adverse selection.

Put another way, there is a tension between limiting adverse selection in health insurance, on the one hand, and fostering innovation through market incentives, on the other. The ACA's framework limits adverse selection but also limits innovation. Might there be a way for us to have our cake and eat it too? Could reforms limit adverse selection while also fostering more innovation through market incentives? Our tentative answer is yes.

We will now explain how a modified version of Cruz's proposal could leave greater scope for innovation while still limiting adverse selection. One option would be for the federal government to commit to offering sufficient subsidies for those who purchase compliant plans, so that sicker individuals would not be priced out of the market. However, the cost of such subsidies

⁵ See Gamage, "Perverse Incentives Arising From the Tax Provisions of Healthcare Reform: Why Further Reforms Are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers," 65 *Tax L. Rev.* 669, 676-679 (2012).

⁶ That is because the plans are forbidden from increasing prices only for sicker and more costly insureds.

⁷ For a more in-depth discussion of a similar dynamic outside the health insurance context, see Gamage and Allon Kedem, "Commodification and Contract Formation: Placing the Consideration Doctrine on Stronger Foundations," 73 *U. Chi. L. Rev.* 1299, 1343-1347 (2006).

⁸ See John H. Cochrane, "After the ACA: Freeing the Market for Healthcare," June 2014.

would be very large. In any case, that is not part of Cruz's proposal.⁹

Consider another potential modification to Cruz's plan. Rather than the federal government undertaking to provide subsidies for compliant plans using general revenue, the federal government could instead tax noncompliant plans and then use the revenue to subsidize compliant plans. Those subsidies could either be in the form of direct payments to compliant plans (to reduce premiums) or in the form of tax credits made available to individuals and families who purchase compliant plans (to make those plans more affordable after tax).

Ideally, the size of those taxes and subsidies would be readjusted annually, with the size of the taxes and subsidies set to approximate the cost of complying with the ACA's consumer protections. Put another way, the size of the taxes and subsidies should be set to approximate the externality that noncomplying plans impose on complying plans through adverse selection.

With that new proposed regulatory framework in place, health insurance providers would have greater freedom to devise innovative health insurance offerings. Any such offering that served the public good by creating more value for consumers than costs in the form of adverse-selection externalities to compliant insurance plans should be profitable for the insurance provider even after the state-level taxes and subsidies. But plans that innovated only to drive away sicker insureds should not be profitable after the taxes and subsidies.

Of course, that modification would require that the federal government impose a large new tax *and* provide large subsidies. Again, that is not part of the Cruz plan. But, were the Cruz plan to be adopted, a state government could then adopt this approach. In other words, a state government could impose a tax on noncompliant plans to force

them to internalize the cost of driving away sicker insureds.

Were a state government to do so, under the current federal regulatory framework we would recommend that the state government use state-level tax credits for purchasing compliant plans rather than direct payments to compliant plans. That is for two major reasons. First, to the extent desired by the state government, those tax credits could be scaled to income to provide more benefit to the state's low-income citizens. Second, using subsidies to reduce the premiums charged for exchange-based plans would result in a state's citizens receiving smaller tax credits from the federal government. By contrast, providing additional state-level tax credits would not reduce the pretax price of the premiums for compliant exchange-based plans. Thus, that approach would not reduce the size of the federal tax credits available to a state's citizens.

There is an interesting analogue to our proposal already being used at the state level. In the realm of education finance, there is a tension between the supposed efficiency and democratic accountability of local control versus the inequities that result from local control in a world where wealth is unevenly distributed. Ultimately, all states aim to strike a balance between those competing considerations, primarily through their tax systems. Sometimes the balance is explicit, as in Texas's "Robin Hood" system, whereby wealthier school districts can provide more funding for themselves but must also pay into a fund for poorer districts.¹⁰ In other states, the state provides a foundation level of funding for all school districts using general tax dollars that individual districts can supplement with local taxes.¹¹

States could approach health insurance regulation in a similar way if confronted by something like the Cruz proposal. On the one hand, under the Cruz proposal, the federal

⁹The BCRA would continue to offer subsidies to some poorer consumers in order to purchase compliant plans, but those subsidies would be smaller relative to the ACA, as would the number of consumers eligible for those reduced subsidies. See Karen Pollitz and Anthony Damico, "Uneven Playing Field: Applying Different Rules to Competing Health Plans," Kaiser Family Foundation. The Kaiser Family Foundation estimates that there would be 6.1 million individuals who would not receive any credits under the BCRA, but who had under the ACA. Of these, the foundation estimated that about 1.5 million have preexisting conditions and thus would face extremely high premiums. *Id.*

¹⁰That is a rough approximation of a complicated system with many options. For the law, see Texas Education Code chapter 41. See also, Texas Association of School Boards, "Overview of the School Finance System," Financial Responsibility Guide (2016).

¹¹That is also a rough approximation. For a more precise overview, see Deborah A. Verstegen, "How Do States Pay for Schools? An Update of a 50-State Survey of Finance Policies and Programs" (2014).

government would allow those well-off (in health, wealth, or youth) to benefit from being able to purchase health insurance plans better tailored to their needs. That tailoring could be because of either socially beneficial innovation or the health plans cutting benefits for the sickest insureds while increasing benefits for the relatively healthy. By taxing noncompliant plans while providing tax credits to fund the purchase of compliant plans, state governments could counteract the incentives and social costs for insurers to take the second strategy.

Of course, state governments will not be able to strike that balance perfectly, no matter how well the taxes and subsidies are designed. One potential advantage of leaving the design of taxes and subsidies to state governments is that each state government could attempt to strike that balance based on its specific conditions and policy preferences.

More generally, we think health reform could benefit from more developed thinking about how state governments might play a useful role in concert with the federal government. However, understanding state taxing capacities and fiscal federalism will be essential for such thinking to bear fruit. We thus hope to continue to explore the intersections of health reform and state and local taxation in future scholarship, and we hope others will join us in this effort. ■

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