

How The Tax Exclusion on Employer-Based Health Insurance Hurts Behavioral Health

The tax exclusion for employer-sponsored health insurance distorts healthcare for everyone, but it has particularly bad effects for individuals who seek care in the area of behavioral health.

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In the U.S., approximately 165 million Americans (workers and families) get their health insurance through an employer. Because employer-sponsored insurance (ESI) premiums are excluded from taxable income, workers have a strong incentive to take more compensation in the form of employer-selected coverage rather than taxable wages they could use to purchase care or insurance directly. Economists have long criticized this tax preference for encouraging the purchase of more insurance and distorting health care markets.¹ It is bad generally, but it can also be seen as particularly bad for certain categories of care. One such category is behavioral health.

In behavioral health, treatment is often recurring, individualized, and preference-sensitive, adult psychiatric provider supply is unusually constrained, and new technologies are rapidly expanding the ways care can be delivered. The tax preference introduces distortions in two main ways. First, it encourages workers to commit more of their compensation to insurance, shifting purchasing power to third-party payers that can shape both the care patients can access and the services providers have incentives to develop. Second, it concentrates purchasing power in the employer market, potentially affecting how scarce psychiatric provider capacity is allocated across competing payer markets.

Inside ESI: Commits Dollars to Coverage Too Early

In behavioral health, much of the insured treatment consists of recurring outpatient care in which patients and clinicians make evolving decisions about frequency, duration, clinician, and approach. Those decisions are very individualized: treatment response varies greatly across psychiatric patients,² and patients differ in the characteristics of treatment they value.³ Consistent with those distinctive features, privately insured adults with behavioral health conditions use out-of-network care substantially more often than patients with diabetes or congestive heart failure, exposing them to higher cost-sharing.⁴

For example, patients go out-of-network to see psychiatrists 8.9 times as often as they do for other medical and surgical specialists. They go out-of-network to see psychologists 10.6 times as often as they do for other medical and surgical specialists.⁵

That creates a particular tension with ESI. The tax exclusion encourages workers both to devote more of their compensation to insurance and to commit those dollars upfront to a specific

kind of employer-selected financing arrangement. That is problematic because in behavioral health, patients often don't know which clinician will be a good therapeutic fit, which treatment approach will work, how intensive or prolonged treatment will need to be, or which forms of care they will ultimately value.

ESI creates an incentive to commit dollars to a comprehensive insurance policy before many of those questions can be answered. Those dollars are less flexible when they come attached to a particular insurance arrangement, including its provider network and coverage rules. That constrains the ability of patients to seek care outside those arrangements. It also constrains providers' incentives to develop different ways of meeting patients' needs. When purchasing power is concentrated in these third-party payers, providers and innovators have greater reason to design services around what those payers will finance rather than discovering what patients themselves would choose to purchase.

It is also important for people who use behavioral health services to retain as much flexibility with their dollars as they can because many behavioral health services are potentially amenable to new modes of digital and technology-enabled delivery, creating opportunities to complement clinicians and offer alternatives to traditional treatment.⁶ But when workers have already been encouraged to commit more of their compensation to comprehensive insurance, a new model must compete not only for patients' willingness to pay but also for access to dollars already committed to third-party payers. The ESI tax preference may therefore make it harder for alternative models to win patients' dollars—even when those models might better match some patients' needs or preferences.

Outside ESI: Psychiatric Care Is Unusually Supply-Constrained

More than many other areas of care, behavioral health is unusually supply-constrained. A recent study found that adult psychiatry had the lowest workforce adequacy among 21 physician specialties.⁷ HRSA's National Center for Health Workforce Analysis estimates that 40% of the U.S. population lives in a Mental Health Professional Shortage Area.⁸

When demand already exceeds available provider capacity, increasing purchasing power in one payer market can affect how scarce provider capacity is allocated across populations. By subsidizing the purchase of insurance through employers, the tax exclusion increases purchasing power in the commercial employer market relative to what would occur under tax-neutral compensation. Patients in competing payer markets may therefore face greater difficulty accessing care.

The effects can be especially consequential for patients transitioning out of ESI. A job loss or change can require a patient to change insurance arrangements and potentially provider networks. This instability is not unique to behavioral health, but its consequences can be particularly disruptive when the value of care depends partly on continuity with a specific clinician and a therapeutic relationship built over time.⁹

Toward Tax Neutrality

Behavioral health illustrates why the allocation and control of health care dollars can matter as much as their quantity. In a market characterized by individualized treatment, unusually constrained adult psychiatric provider supply, and rapidly evolving ways of delivering care, the tax code influences not only how much Americans insure but when and where their health care dollars are committed, how patients in different payer markets compete for scarce provider capacity, and which emerging alternatives can compete for patients' dollars.

The distortions inside and outside ESI look different, but they share an upstream source: the unequal tax treatment of health insurance depending on whether it is purchased through an employer.

The cleanest way out of this arrangement is to end the distortion, so that health coverage receives the same tax treatment no matter who arranges it or how it is purchased.

Employer-sponsored insurance doesn't necessarily have to disappear, but the uneven incentives do. A better system would free workers to purchase care and coverage that best fits their needs, without nudging them one way or another.

Tax neutrality would not, by itself, solve every problem in health care or behavioral health. But it would remove a major distortion and allow a more robust individual market to develop alongside other types of coverage. Rather than using the tax code to steer people toward one particular way of financing health care, policy should allow consumers and patients to choose.

About the Author

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The author has declared no potential conflicts of interest with respect to the research, authorship, or publication of this article.

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