EBRI ISSUE BRIEF

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CHANGING THE TAX TREATMENT OF HEALTH BENEFIT PROGRAMS

Recently, there has been growing public discussion on tax treatment of employer-sponsored health benefits. Employer contributions to health plans are tax deductible business expenses and the benefits to employees are not taxed. Modifications to current tax treatment have been proposed in two contexts: (1) What is an equitable distribution of federal health expenditures among different income groups -- especially at the present when there are major efforts to reduce the federal budget? and (2) How can we effectively control health care cost inflation?

Before considering health benefit taxation, policymakers must have access to accurate information and sound policy analysis. To date they do not.

The Distribution of Federal Health Expenditures

The absolute and relative costs of health care "subsidies" among various income groups is one area where accurate information is essential. Gail R. Wilensky of the National Center for Health Services Research (NCHSR)[1/] attempted to provide such information in her paper entitled, "Government and the Financing of Health Care" at the American Economic Association meeting in Washington, D.C. on December 30, 1981.

An article reviewing Wilensky's paper appeared in the Washington Post on December 31, 1981 under the headline: "U.S. Spending for Health Care for Rich Same as for the Poor." This headline highlights a major point stressed in Wilensky's paper and AEA presentation. Wilensky based her presentation on 1977 National Medical Care Expenditure Survey (NMCES) data. However, this survey considered in total does not support Wilensky's conclusions.

To develop her thesis that health care expenditures are similar for the rich and poor, Wilensky categorizes the population into four groups according to their 1977 family income relative to the 1977 poverty line. This distribution of the population into income categories is shown in Table 1. The actual category to which a particular family was assigned depended on family income and the appropriate poverty line based on family composition (i.e., sex of head, age and number of household members) for those in the NMCES. A family of four with an income up to $9,999 is classified as "poor or near poor." Those with $32,000 or more incomes are described as having "high incomes" by Wilensky and "rich" by the Washington Post.

[1/] NCHSR is part of the Department of Health and Human Services.

Table 1

Wilensky's Distribution of Population into Four Income Categories

Category	Family Income in Relation to 1977 Poverty Line (PL)	Family Income Breaks for Family of Four	Percentage of Total Population
Poor & Near Poor	Up to 1.25 times PL	Up to $9,999	14%
Other Low-Income	1.26 to 2 times PL	$10,000 to $15,999	15%
Middle-Income	2 to 4 times PL	$16,000 to $31,999	39%
High-Income	More than 4 times PL	$32,000 or more	32%

Source: Gail R. Wilensky, "Government and the Financing of Health Care" (Paper presented at the American Economic Association meeting, Washington, D.C., December 30, 1981), pp. 6-7.

Wilensky focuses on three federally subsidized health care programs: Medicare, Medicaid and "tax expenditures." "Tax expenditures" are the foregone federal revenues that "result from the exclusion of all employer-provided insurance contributions and from the deductibility of certain medical expenses." Additionally, "states with an income tax lose revenue from excluding the employer contribution, and neither employers nor employees pay Social Security taxes on this income." Wilensky calculates that the costs of health benefit tax expenditures in 1977 were $10.3 billion. Medicare costs were $15.4 billion and Medicaid costs were $9.1 billion. Table 2 shows these programs' benefit distribution according to Wilensky.

Wilensky concludes:

> "The distribution of medical expenditures favoring the poor is offset by the distribution of tax expenditure (sic) in terms of premiums and other medical deductibles, which favor the high-income sector. Thus government expenditures associated with these programs goes in equal proportion to the high- and middle-income population and the poor. It is the low-income group which benefits least."

Wilensky's analysis is flawed for several reasons:

1) Medicaid payments provided to individuals in skilled nursing and intermediate care facilities are not considered. Thus Wilensky ignores over 40 percent of the total Medicaid benefits that go almost exclusively to low-income persons.

2) Veterans' health benefits are also not considered. According to the Annual Report of Administrator of Veteran Affairs, medical services and administrative expenses in fiscal 1977 were $5.1 billion.[2]

3) The actual data presented in Wilensky's paper contradict her assertion that government medical expenditures "goes in equal proportion to the high- and middle-income population and the poor. It is the low-income group that benefits the least." For example: Per capita expenditures show that low-income groups receive proportionately greater benefits than middle- and high-income groups. According to Wilensky's analysis, the "poor and near poor" receive 29 percent of benefits; however, they make up only 14 percent of the total population. Alternatively, the middle-income group receives only 27 percent of benefits but comprises 39 percent of the population. The high-income group receives 28 percent of the benefits while comprising 32 percent of the population.

4) The "benefits" ascribed to the "high-income" class warrant closer scrutiny. Two-thirds of these benefits are "tax expenditures." They result strictly from the high marginal tax rates applied to gross incomes in excess of $32,000. Future marginal tax rates for most households may be lower than Wilensky posits, particularly with passage of the 1981 Economic Recovery Tax Act. Lower marginal tax rates for higher income individuals would reduce tax expenditure estimates.

5) There is also some evidence that Medicare and Medicaid reimbursement rates do not satisfy the full costs of benefits provided under these programs. This suggests that health service vendors may overcharge other customers (i.e., patients) to offset the shortfall. Such "cost shifting" raises the costs and premiums of employer health programs. Private subsidization of public programs understates the Medicaid and Medicare benefits going to lower-income groups while inflating the tax expenditures ascribed to higher-income groups.

Wilensky notes that her "results suggest that attempts to curb government health expenditures must focus on tax expenditures as well as on Medicare and Medicaid, since this component plays an important part in determining the distributional effects of overall government expenditures." The clear implication is that any reduction of federal health subsidies should include a change in policy that would tax future employer-sponsored health benefits. The potential effects on health care delivery are not considered.

[2]U. S. Department of Commerce, Bureau of Census, Statistical Abstract of the United States: 1980 (Washington, D.C.: U. S. Government Printing Office, 1980), p. 385.

Controlling Health Care Cost through Pro-competition Legislation

There is widespread public concern about increasing health care costs in the United States. According to the Department of Labor, while overall consumer prices rose 8.9 percent in 1981, medical care costs rose 12.5 percent. During the seventies, the CPI rose 87 percent while medical costs doubled. A number of factors contributed to medical cost increases. Two reasons that have been cited frequently are: 1) the government's payment of medical bills for large portions of the population through Medicare and Medicaid programs; and 2) payment of medical bills by employer-provided health insurance programs. In both instances, third party payment of medical bills shields consumers from actual medical care costs and this may encourage excessive consumption.

The federal government has a strong influence on both public and private health care programs. Under Medicare and Medicaid, the government plays a direct role in establishing program eligibility as well as reimbursement rates. The federal government affects private employer-sponsored programs principally through tax incentives today.

The intractable nature of health cost inflation along with government's encouragement of broad health insurance coverage has led to a series of legislative proposals aimed at controlling health care costs. Public health care programs (i.e., Medicare and Medicaid) can be modified to limit coverage eligibility and reimbursement rates. Pro-competition legislation proposals, designed to affect employer health benefits, generally have two common features: 1) They would require that employers with health benefit programs provide employees with a range of insurance packages. 2) They would provide a set of financial incentives aimed at encouraging efficient health care utilization by those insured. Proposals that are now under consideration would tax employer contributions to health programs where such contributions are above a defined limit. These proposals also call for larger deductibles and copayments. Some legislative initiatives would provide cash rebates to individuals who elect low-option health insurance coverage. Theoretically, the financial incentives, along with the increased health coverage options, would discourage overinsurance and overutilization of health services.

Critics of pro-competition legislation argue that the theory behind these proposals may be flawed. For example: Lawrence D. Brown of The Brookings Institution suggests that although competition may work in Minneapolis-St. Paul, Hawaii and Clackamas County, Oregon it may not work everywhere. He argues that it is equally plausible that these situations are idiosyncratic and may be highly dependent on local community, medical and organizational leadership and coalitions. And it may be dependent on other supportive social structures that are found in some places but not in others.[3/]

[3/]Lawrence D. Brown, "Competition and Health Cost Containment: Cautions and Conjecture," Health and Society, vol. 59, no. 2 (Spring 1981), p. 186.

Other critics argue that health benefits taxation and mandatory provision of multiple-option health programs could jeopardize the existence of employer-sponsored health protection. Where individuals anticipate health problems, benefit taxation above certain amounts would encourage choice of higher option coverage by persons most likely to need it (i.e., persons for whom the potential value of actual medical costs reimbursement exceeds the incremental tax liability). Requiring employers to contribute equal amounts to each employee's coverage, with rebates to employees who select lower coverage, could exacerbate this problem. Given the opportunity to increase their cash income, low-income workers with relatively low risk aversion are likely to select lower coverage. However, these individuals may incur higher medical expenses. If individuals make the wrong choice, will they be denied needed medical care, or will catastrophic insurance and public programs satisfy their needs? If the latter event ensues, competition measures could result in substantial cost shifting with little cost saving.

Some feel that employers and insurance carriers are "crying wolf" when they raise the issue of adverse selection in response to the pro-competition health policy proposals. Nonetheless, the potential of public policy induced adverse selection may jeopardize the sponsorship of employer health programs. The "competition" proponents have not yet fully addressed this problem. Furthermore, there is little evidence demonstrating that these proposals will reduce overinsurance, overutilization or health cost inflation.

The federal government should test the conventional wisdom imbedded in various pro-competition proposals. The federal government offers its workers a wide range of health insurance options with scheduled re-enrollment periods. Workers can choose from a number of insurers and HMOs as well as a variety of high- and low-option plans. Employees have monthly coinsurance premiums ranging from roughly $5 to $75. U.S. federal workers are dispersed throughout hundreds of communities with considerable health cost variance.

The diversity of plans available and the range of worker premiums suggest that federal workers should already be "efficient" health service consumers. To date, however, there is no systematic study which assesses how federal workers select their health benefits or change their health insurance coverage during the annual "open season." There is no systematic evaluation of health utilization levels relative to health insurance coverage or changes in coverage. With the exception of the taxation and rebate provisions, the flexibility sought in most pro-competition bills has already been accomplished by the Federal Health Benefits Program. Basic research is needed to fully understand the potential effects of changes in legislation and federal regulation of health benefit programs.

Given the far reaching implications of competition proposals, the benefits of research would far outweigh the costs.

Tax Treatment of Health Benefits: A General Perspective

There are several fundamental questions that remain unanswered.

First, health benefits are "in-kind" income. Should they be selectively subjected to income and payroll taxes or should other employer in-kind benefits also be taxed? If the Congress decides to tax employer in-kind income, should government provided in-kind benefits (e.g., Medicaid, Medicare, food stamps, housing subsidies), also be taxed? If in-kind benefits are taxed, how should they be valued--at the cost of providing them or at their value to the recipient? How would variations in health benefit costs by geographic location be treated? Will New York City workers pay more in taxes than Kansas City workers because New York City insurers charge higher premiums?

Second, the current treatment of employer-provided health benefits makes up a relatively small part of the total "tax expenditures" now estimated by the Office of Management and Budget. For example, Wilensky noted the importance of exempting health benefits from the Social Security payroll tax. If federal civilian wages and salaries were subject to Social Security taxes during 1982, it would generate an additional $8.7 billion in 1982 Social Security revenues.[4/] Other significant "tax expenditures" include deductible mortgage interest payments, favorable capital gains treatment, nontaxable Social Security benefits and deductible nonbusiness state and local taxes.

Third, can anyone demonstrate that taxing health benefits will accomplish the intended goals?

If taxation of benefits occurs simultaneously with Medicare and Medicaid reductions, neither the relative nor absolute share of federal health benefits to the poor will necessarily increase. Furthermore, the inflation reducing effects of pro-competition tax provisions are, at this time, only theoretical conjecture. Brown contends that "At this stage in the development of market approaches in the health field, policy advocacy should take a distant back seat to policy analysis; that is, to the patient and dispassionate search for empirical evidence that bears clearly on hypotheses founded on a mere handful of interesting facts."[5/]

[4/]Estimate by the Social Security Administration, Office of the Actuary included in: Sylvester J. Schieber, "Universal Social Security Coverage and Alternatives: The Benefits and Costs" (Paper presented at the American Enterprise Institute Conference on Controlling Social Security Cost, June 26, 1981), table 4.

[5/]Brown, "Competition and Health Cost Containment: Cautions and Conjecture," p. 186-187.

Table 2

Major Federal Government Expenditures on Health, 1977

All Persons	Per Capita Government Expenditures: Income Tax Savings	Medicare[a]	Medicaid	Total Federal[b]
Poor and near poor	$ 2	$141	$184	$327
Other low-income	16	99	63	178
Middle-income	43	57	16	116
High-income	90	48	4	142

All Persons	Total Expenditures (in billions): Income Tax Savings ($)	Income Tax Savings (%)	Medicare ($)	Medicare (%)	Medicaid ($)	Medicaid (%)	Total ($)	Total (%)	Population Share (%)
Poor and near poor	0.1	1	4.3	28	5.6	62	10.0	29	14
Other low-income	0.5	5	3.1	20	2.0	22	5.6	16	15
Middle-income	3.5	34	4.7	31	1.3	14	9.5	27	39
High-income	6.2	60	3.3	21	0.2	2	9.7	28	32
Total expenditures	10.3	100	15.4	100	9.1	100	34.8	100	100

[a]Less Part B premiums.
[b]Excludes expenditures from veterans' programs and small federal programs.

Source: Gail R. Wilensky, "Government and the Financing of Health Care" (Paper presented at the American Economic Association meeting, Washington, D.C., December 30, 1981), pp. 7, 12.