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The Tax Treatment of Health Insurance and Employment-Based Health Benefits

by Paul Fronstin, EBRI

- ***Tax treatment of health benefits*—**Various proposals have been made to change the tax treatment of health coverage, which currently is tax free to both employers and workers. Proponents of these changes argue, among other things, that current tax rules are unfair and contribute to unnecessary spending for health care. This *Issue Brief* examines changes that policymakers are discussing, explores the history of tax laws concerning the tax treatment of health benefits and the cost to the federal government in foregone taxes because of these laws, and examines some the advantages and disadvantages that could result from the proposed changes.
- ***Estimated cost in tax revenue*—**Health benefits account for one of the largest tax expenditures in the U.S. budget. Estimates for personal federal foregone tax revenue in 2006 related to the exclusion from individual income of employer contributions to health benefits ranged from $91 billion (Joint Committee on Taxation) to $133 billion (Office of Management and the Budget).
- ***Major proposals*—**The most significant proposals for changing the tax status of health benefits are:
  - ► *Limiting the tax exclusion for health benefits* to $5,000 for individual coverage and $11,500 for family coverage obtained through an employer or purchased directly from an insurer. This proposal was included among the recommendations of a 2005 presidential advisory panel.
  - ► *Expanding health savings accounts* (HSAs) and high-deductible health plans (HDHPs). Under this plan, which President Bush advocates, individuals would be able to deduct the full premium for a HDHP used in conjunction with an HAS, even if purchased directly from an insurer.
  - ► *Allowing full tax deductibility of health care expenses* from income. Under this proposal, individuals would be able to deduct all out-of-pocket health care expenses as a way to encourage more people to adopt less comprehensive coverage with more cost sharing.
- ***Assessing the trade-offs*—**Since health insurance coverage produces a number of positive external societal benefits, withdrawing the current tax incentive implicitly would suggest that individuals would obtain less-than-optimal medical care. Currently, that incentive is provided through an employment-based system that has systemic efficiencies that an individual-based system would not be able to equal. Any honest debate of overhauling the federal tax treatment of health coverage in the United States needs to address not just what a new system might do, but what the trade-offs and unintended consequences might be, and who would be likely to be most affected by the change.

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Introduction

Employment-based health benefits are the most common source of health insurance among persons under age 65 in the United States. More than 159 million individuals under age 65 had some form of employment-based health benefits during 2004 (Fronstin, 2005).

Employers provide health benefits voluntarily. They offer health benefits to attract and retain qualified workers based on the generally accepted view that most employees desire them more than the equivalent cash compensation and evidence that they outrank every other employee benefit in importance (Helman and Fronstin, 2004). Employers also offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury, to promote health, and to increase worker productivity. They generally regard health benefits as a voluntary compensation arrangement dependent on business priorities, and their level of commitment to this benefit fluctuates in response to a variety of economic pressures. However, they also have a motivation to provide health benefits as a means of protecting their investment in employees. The cost of absenteeism and "presenteeism" (on the job but unproductive) related to health status reduces human capital productivity and can trigger other costs, such as sick pay and disability costs.

The employment-based health benefits system was established many years ago. Early examples of employment-based health programs include the mining, lumbering, and railroad industries during the late 1800s (see citations in Institute of Medicine, 1993). Employers in these industries provided company doctors funded by deductions from workers' wages. Employers had a practical interest in providing health services to injured or ill workers, who often worked in remote geographic regions. Early employment-based programs occasionally covered general medical care for workers, their families, and the community as well.

Historians often suggest that the tax-preferred status of employment-based health benefits led to the rise in its prevalence and comprehensiveness. Claims have been made that employment-based health benefits grew out of Internal Revenue Service (IRS) rulings during the 1940s rendering employer contributions for health insurance tax-exempt for workers and tax deductible for employers (Gabel, 1999), and that the tax-exempt status of health benefits has encouraged employers to offer coverage and to provide more comprehensive coverage than they otherwise would have (Sheils and Haught, 2004).

It was during World War II that many employers began to offer health benefits, and subsequently the number of persons with employment-based health benefits started to increase. Because the National War Labor Board froze wages, employers sought ways to get around the wage controls in order to attract scarce workers. In 1943, the National War Labor Board ruled that employer contributions to insurance did not count as wages, and, thus, did not increase taxable income. Health insurance benefits were an attractive means to recruit and retain workers. Unions supported the provision of employment-based health benefits, and workers' health benefits were not subject to income tax (or Social Security payroll taxes), as were cash wages. According to Hacker (2002), however, there were even larger motives and forces that drove the expansion of employment-based health benefits, evidenced by the fact that enrollment in Blue Cross increased faster between 1940 and 1941 than in the following wage-freeze years.

Growth in employment-based health benefits accelerated during and after World War II for numerous reasons (Helms, 1999). By the end of the war, health insurance coverage in the United States had tripled, not because of the tax treatment of health benefits (which was unclear at the time), but because employers had to compete for labor at a time when there were labor shortages (Weir et al., 1988). It was not until the Revenue Act of 1954 that the Internal Revenue Code made it clear, after a number of conflicting IRS rulings prompted Congress to demand a blanket exception, that employer spending on employee health benefits was not counted as employee income (Hacker, 2002).

Whether or not the tax treatment of health benefits was responsible for its growth in the work place, both in terms of the number of workers with coverage and the comprehensiveness of that coverage, the preferential tax treatment of health benefits is one of the largest tax expenditures in the U.S. budget. It has been estimated that the preferential tax treatment of health benefits accounts for about $200 billion in forgone tax revenue to the U.S. and state governments (Sheils and Haught, 2004). Personal federal foregone

tax revenue in 2006 related to the exclusion from individual income of employer contributions to health benefits was estimated by the Joint Committee on Taxation to be $90.6 billion[1] and by the Office of Management and the Budget to be $132.7 billion.[2] While there is no agreement on the exact size of the foregone tax revenue, health benefits account for more foregone tax revenue than the deductibility of mortgage interest, and is only second in size to tax revenue that is *deferred* (as opposed to foregone) due to retirement savings contributions and earnings.

Some economists have argued that the tax preference afforded employment-based health benefits provides an incentive for the purchase of too much insurance, which distorts the market for health services, yields an inefficient allocation of scarce resources, and promotes health care cost inflation (Feldstein, 1973; Feldstein and Friedman, 1977; Pauly, 1986). It has also been argued that the tax preference is a regressive subsidy in that it benefits higher-income individuals.

Because of the size of the tax exclusion and the implication that the tax treatment of employment-based health benefits is a major cause of economic inefficiency in the health care industry, there is strong interest among policymakers and others in fundamentally changing the tax treatment of health benefits. Capping the exclusion from income enjoyed by employment-based health benefits has been suggested recently (it was also proposed by the Reagan Administration in S. 640 in the 98th Congress), and there is also interest in providing tax credits for the purchase of insurance and for increased deductibility of premiums in the individual market and out-of-pocket expenses generally.

This *Issue Brief* examines fundamental tax reform as it relates to employment-based health benefits. This study summarizes the current tax status of health benefits and insurance, discusses implications for health care coverage and the uninsured, and addresses the implications for plan sponsors and public policy.

The Rationale for Subsidizing Employment-Based Health Benefits[3]

The assertion that the tax subsidy of employment-based health benefits distorts the market for health insurance and therefore creates an inefficient allocation of resources is based on the assumption that the tax subsidy is the only reason the market for health care services is inefficient. If there are other factors preventing the health care financing and delivery system from performing optimally, however, the "theory of second best" suggests that removing the tax incentive may not increase social welfare.

There are two reasons why the health care delivery system may not allocate resources efficiently in the absence of a tax incentive for health benefits. The use of health care services by individuals has benefits to society at large. Furthermore, individuals have more information about their health status than insurers. Those with the greatest *need* for health insurance tend to be those with the greatest *risk* for needing health care. As a result of this asymmetric information, insurers either have to go to the expense of acquiring information on the individual's health status or raise premiums to account for the greater demand by those mostly likely to file a claim.

One argument for some mechanism for subsidization of health insurance rests on the notion that there are benefits to society that arise from individuals' use of health care services. The presence of positive external benefits implies that, without an incentive, individuals would use less health care than society as a whole would find optimal. That the incentive is provided through employment is a consequence of the efficiency of the employment-based system in providing coverage.

The employment-based health benefits system allows risks to be pooled more broadly than an individual insurance market can sustain. The existence of economies of scale in the provision of group health benefits results in a lower average cost. When economies of scale exist, the average administrative costs of providing health benefits to a group make up a smaller percentage of the cost of health coverage.

An employer's decision to offer health benefits will depend upon the demand for health coverage by the work force the employer wants to recruit and retain. Controlling for income, generally good risks will have a lower demand for health insurance than poorer risks. Increasing the tax preference for health insurance lowers the effective price of that coverage, inducing more good risks to demand employment-based coverage. Whatever decision rule the employer uses in choosing whether to offer coverage, the greater the demand for it by workers, the more likely employers are to offer coverage.

In summary, the lower the effective price of coverage, the more good risks will desire to purchase insurance. As the demand for insurance increases, more employers will elect to offer coverage. Once offered as part of workers compensation, the vast majority of employees participate, which reduces the effects of adverse selection. Thus, the group purchase of health coverage through employment makes that coverage more affordable to the most vulnerable members of society (the poorer risks).

Current Tax Treatment of Employment-Based Health Benefits

The tax treatment of health benefits has been fortified in the tax code through a series of laws and rulings that date back to the 1920s. Currently, employers can deduct from taxable income the cost of providing health benefits as a business expense. This means that whatever an employer spends on behalf of workers on health insurance or health benefits is considered a business expense, just as wages and salaries are a business expense. In other words, employers get the same deduction in calculating taxable income when they choose to provide compensation in the form of health benefits as they would were they to provide compensation in the form of wages and salaries, and they should therefore be indifferent from an income tax point of view between providing health benefits or cash wages. Employers do, however, get a break on payroll taxes when compensation is provided in the form of health benefits instead of wages and salaries: They do not pay the 6.2 percent payroll tax for Social Security for workers whose incomes are below the Social Security wage base, which was set at $94,200 in 2006.[4] They also do not pay the 1.45 percent payroll tax for Medicare for all levels of wages. Employer savings related to the Social Security payroll tax accounted for about $26 billion in 2004, while the Medicare payroll tax savings accounted for about $7 billion.[5]

For workers, the amount that employers contribute toward health benefits is generally excluded, without limit, from taxable income. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for out-of-pocket health care expenses with pretax dollars, meaning they are not taxed on the amount of money that is put into the FSA. Employers can also make available a premium conversion arrangement, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars.

Individuals are able to deduct from taxable income contributions made to a health savings account (HSA), if they have health insurance with a deductible of at least $1,050 for individual coverage or $2,100 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a $5,250 maximum out-of-pocket limit for individual coverage, and a $10,500 limit for family coverage. There are other restrictions as well. Regardless of who contributes to the account, annual contributions are tax free to the individual who owns the account, up to a limit of the lesser of the deductible or $2,700 for individual coverage, and for family coverage the lesser of $5,450 or the embedded deductible (the deductible applying to one individual) multiplied by the number of covered family members (Lyke, 2005). Those ages 55 and older can make "catch-up" contributions to an HSA as well. In 2006, a $700 catch-up contribution was allowed, and is being phased in to $1,000 by 2009. Unspent balances in an HSA grow tax free, and distributions from an HSA are tax free when used for qualified medical expenses and certain premiums.

For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return. This deduction is not widely used, because the standard deduction is larger than the sum of itemized deductions for most taxpayers, and most do not have deductible medical expenses that exceed 7.5 percent of AGI. In 2001, about one-third of all individual income tax returns had itemized deductions, but only 17 percent of these claimed a medical expense deduction, accounting for about 6 percent of all tax returns (Lyke, 2005). There is one exception to the 7.5 percent AGI rule, however: Contributions to an HSA are fully deductible from taxable income and are not subject to the 7.5 percent AGI threshold.

Regressive or Progressive?

The tax preference for health insurance is generally viewed as being regressive, in that the tax exclusion benefits higher-income individuals more than lower-income individuals. The regressive tax structure enables workers in higher tax brackets to receive greater tax advantages in dollar amounts than those received by

lower-paid workers. This occurs because, although the amount of the benefits is generally the same for all workers with the same employer regardless of income, high-income workers face a higher marginal tax rate.

Figure 1 illustrates premiums as a percent of income and the tax savings of the health insurance tax exclusion to families with different income levels. Premiums represent a much greater share of income for low-income families than for high-income families. For a family with $10,000 in income, a $10,000 employer-paid premium represents 100 percent of its income. However, for a family with $100,000 in income, the same $10,000 employer-paid premium represents only 10 percent of its income.

Under the 2005 tax rate structure, the first two families in Figure 1 face marginal tax rates of 10 per-cent and 15 percent, respectively. If $10,000 in health insurance premiums were excluded from income, the tax savings attributable to health insurance would be $1,000 to the $10,000 income family, and $1,500 for the $45,000 income family. For the third family, with $100,000 of taxable income and a 25 percent marginal tax rate, the tax savings from the exclusion is $2,500, and it increases to $3,500 for the family with $400,000 of taxable income. The tax exclusion amounts to more than three times as much to families in the 35 percent tax rate bracket as it is to families in the 10 percent bracket. Under the tax code, there is no tax savings for families with no taxable income.

Figure 2 shows that tax savings related to health care tend to benefit high-income families more than lower-income families in terms of the distribution of the tax exclusion across family income, as compared with the percentage of families in those income categories. However, as a *percentage of income*, the exclusion may also be viewed as progressive, as the exclusion represents greater savings for lower-income families than for higher-income families (Institute of Medicine, 1993). Again, looking at Figure 1, for a $10,000 health plan, the tax savings is 10 percent of income for family one, 3.3 percent for family two, 2.5 percent for family three, and 2 percent or less for the other families.

Figure 1 shows that, while the exclusion is greater in dollar amounts for the families with higher income, as a percentage of income the relative amount of tax savings falls as income rises. When examining the tax exclusion by the percentage of income, it should be noted that it is not progressive at all income levels. Families with no taxable income receive no tax exclusion because they pay no taxes. A refundable tax credit (which is paid to the taxpayer even if the amount of the credit exceeds the tax liability) would result in a reduction in taxes for these families.

The analysis above includes only the impact of the federal income tax on employment-based health benefits. Additional tax savings are realized by employees and employers as a result of not having to pay Medicare and Social Security taxes. Figure 3 incorporates payroll taxes into the analysis. The incorporation of payroll tax savings reduces the degree to which the exclusion of health benefits from taxable income is regressive. Families with income below the Social Security wage base ($90,000 in 2005) receive additional tax savings of $765 on a $10,000 health insurance policy. Families with income above the wage base receive an additional $145 in payroll tax savings. This increases the progressive aspect of the tax code when examined from the point of view of tax savings as a percentage of income. For families with $10,000 in taxable income, the exclusion as a percentage of their income increases from 10 percent to 17.7 percent after including payroll taxes. For families with $100,000 in taxable income, the exclusion as a percentage of income remains constant at about 2.5 percent.

Knowledge of Tax Treatment of Health Benefits

Many small employers make decisions about whether to offer health benefits to their workers without being fully aware of the tax advantages that make this benefit more affordable. For example, 57 percent of small employers surveyed in 2002 did not know that premiums for health insurance were 100 percent tax deductible for the employer (Figure 4).

With respect to employers' knowledge about the tax treatment of health benefits as it affects their workers, many make false assumptions. More than one-third were not aware that employees who purchase health insurance on their own generally cannot deduct 100 percent of their health insurance premiums. In addition, 38 percent did not know that employees do not pay tax on the share of premiums paid by their

employer. Employers offering health benefits were much more likely to be aware of this provision in the tax code than those not offering. Seventy percent of employers offering health benefits understood that the employer's share of the premium was not included in an employee's taxable income, compared with 48 percent of employers not offering health benefits.

Even among employers offering health benefits, a surprisingly high percentage still did not understand how those benefits are treated by the tax code. It is important for employers to understand the tax treatment of health benefits, as it can have a significant impact on a sponsor's willingness to continue (or begin) offering the benefit. While small business is generally less likely to offer health benefits than large business because of differences in the cost of providing such a benefit, misperceptions about how health benefits are taxed may contribute to and exacerbate the reasons why small employers do not offer health benefits.

Individuals typically are not knowledgeable about the tax treatment of health benefits as it affects them and their employers, nor are they knowledgeable about the tax treatment of out-of-pocket health care expenses. Slightly over half (57 percent) of individuals understood that health care expenses are generally not tax deductible, and the same proportion knew that the amount that employers pay toward health insurance premiums are fully excluded from their taxable income (Figure 5). Only 43 percent of individuals knew both that 1) workers who buy insurance directly from an insurer cannot generally deduct the premiums paid, and 2) health insurance premiums paid by employers are 100 percent tax deductible as a business expense.

Worker Preference for Health Benefits

Individuals tend to prefer employment-based health benefits over taxable wages when given the choice, in part because of the tax treatment of benefits. When employed Americans with health coverage are asked whether they would prefer $6,700 in employment-based health insurance coverage or an additional $6,700 in taxable income, 80 percent choose the employment-based health coverage. Two-thirds would prefer employment-based coverage to an increase in income even if an employer paid $10,000 toward the coverage (Figure 6). Furthermore, this preference for employment-based coverage emerges regardless of employees' demographic characteristics.

The strong preference that workers have for receiving health insurance through an employer over an increase in wages to purchase insurance directly from an insurer may be related to the fact that workers do not have a high degree of confidence in their own ability to choose the best available health plan for themselves. In 2002, only 27 percent of individuals were extremely or very confident that they could choose the best available health plan if employment-based health benefits were no longer available to them in the work place (Figure 7). Nearly 40 percent were either not too or not at all confident that they could choose the best available health plan. Furthermore, individuals are not highly confident that they could afford to purchase health insurance even if their employer gave them the money spent on their behalf for health insurance. Only 17 percent were extremely or very confident that they could afford to purchase health insurance directly from an insurer if their employer stopped offering health benefits and gave them the equivalent cash (Figure 8), and individuals in lower-income households were significantly less likely than those in upper-income households to report that they were extremely likely to purchase health insurance on their own (Figure 9).

This may be indicative of the fact that individuals are already being affected by rising health care costs relative to affordability and other financial aspects of their lives. Previous research has found that individuals who have experienced cost increases have compensated by making changes in the way they use health care. Some of these changes could be regarded as positive, but others could result in negative consequences. Nearly 80 percent say the increased cost of health care has led them to use generic drugs when available, and 71 percent report they now try to take better care of themselves (Figure 10). Almost 60 percent say cost increases have led them to talk to the doctor more carefully about treatment options and costs; about one-half say they now go to the doctor only for more serious conditions or symptoms. Forty percent have delayed going to the doctor. Less frequent responses to the increase in health care costs include switching to over-the-counter drugs (33 percent), saving additional money in a flexible spending account

(31 percent of those employed), looking for cheaper health insurance (28 percent), and looking for less expensive health care providers (27 percent). Most alarmingly, 21 percent report cost increases have caused them to not take their prescribed medication. Lower-income individuals are more likely to report making each of these changes.

The concern over lower use of health care services stems from the fact that significant cost sharing substantially reduces both appropriate and inappropriate use of all types of health care services (Tollen and Crane, 2002). Findings from the Rand Health Insurance Experiment indicate that the poor tended to have worse health outcomes because of higher cost sharing, especially for conditions like hypertension that are easily treated, but otherwise there was no clear pattern of impact of cost-sharing on health status.

Increased health care costs have also affected household finances, and many of those who have experienced cost increases have coped by reducing the amount they save or by depleting their savings. One-quarter report they have decreased their contributions to a retirement plan as a result of the increased cost of health care, and almost one-half report they have decreased their contributions to other savings as a result of the increases (Figure 11). One-quarter say they have had difficulty paying for basic necessities, like food, heat, and housing, while one-third report difficulty paying other bills. Nearly 30 percent indicate they have used up all or most of their savings and 18 percent have borrowed money. Not surprisingly, those with household income less than $35,000 are especially likely to have resorted to these strategies to cope with health care cost increases. Other research has shown that personal bankruptcy is often associated with out-of-pocket medical expenses (Himmelstein, et al, 2005).

The strong preference that workers have for employment-based health benefits over an increase in wages may also be related to worker skepticism that they would, in fact, receive a dollar-for-dollar increase in wages relative to a reduction in benefits. And for a number of reasons (discussed more fully later in the paper), it may not be realistic to assume that workers will get the full value of their benefits as a wage increase.

Proposals to Reform the Tax Treatment of Health Insurance

Over the course of many years, a number of proposals have been put forth to change the way health insurance is treated by the tax code. In January 2005, President Bush appointed a panel to consider fundamental tax reform. The panel reported its recommendations in November 2005 and included changes to the way health insurance is treated under the tax code. Past presidents, members of Congress, and various organizations, interest groups, and individuals have put forth ideas and recommendations as well. This section provides an overview of options to change the way health insurance coverage is taxed.

Capping the Exclusion of Health Benefits from Employee Income (Commission Proposal)

In November 2005, the President's Advisory Panel on Federal Tax Reform (Panel) released a long list of recommendations to fundamentally change the federal tax code. As part of the recommendations, the Panel concluded that removing the subsidy for employment-based health benefits could lower overall private spending on health care between 5 percent and 20 percent. The theory behind this statement rests on the assumption that, because of the tax-preferred status of employment-based health benefits, workers prefer health benefits over cash wages. Hence, as a result of workers' preference for health benefits, they are "overinsured" and therefore use more health care services than they otherwise would. Ultimately, overuse of health care services drives up insurance premiums and makes insurance less affordable, especially for lower-income workers.

Prominent in the panel's recommendations were changes in the way health insurance is taxed. The panel was mixed in its assessment of whether the tax exclusion for employment-based health benefits is good or bad. On the one hand, the Panel suggested that the tax exclusion is costly and has a negative impact on the market for health care. On the other hand, the Panel concluded that 1) the immediate elimination of the tax exclusion for employment-based health benefits would adversely affect many Americans, and 2) several members felt that the tax code should provide an incentive for individuals to have health insurance. The Panel also recognized that the employment-based health benefits system reduces transaction costs, may

lower premiums for some people who otherwise could not afford health insurance, and may lead to a greater percentage of the population with coverage. These benefits may be lost to the degree that the United States moves away from an employment-based health insurance system.

The Panel did not recommend any changes in the way employer costs for health benefits are taxed. Under the proposal, employer spending on health benefits would continue to be deductible as a business expense.

In terms of the specific recommendations, the Panel recommended that the degree to which employees could receive health benefits on a tax-preferred basis be limited. The panel recommended that starting in 2006, the exclusion from income be limited to $5,000 for employee-only coverage, and $11,500 for family coverage. The exclusion limits are close to the average premium for health benefits in 2005: $4,024 for employee-only coverage and $10,880 for family coverage (Gabel, et al., 2005). Hence, a substantial portion of the population with employment-based health benefits would be required to pay income taxes on the portion of the premium above the exclusion cap if they did not choose a less costly health plan. For example, a family with a health plan premium of $12,000 would be required to pay taxes on an additional $500 in income. A family in the 15 percent tax bracket would pay an additional $75 in federal income tax, while a family in the 25 percent tax bracket would pay an additional $125.

The cap on the tax exclusion would grow over time, such that as the cost of health benefits increased, the amount of health insurance premium that could be excluded from income would also increase. However, the Panel recommended that the tax exclusion cap be indexed to the *overall* rate of inflation, as opposed to changes in *medical* inflation, meaning that if health insurance premiums increase faster than overall inflation, more individuals would be subject to paying income tax on the portion of the premium above the tax cap, if changing the way premiums are taxed does not affect the gap between premium increases and overall inflation. So, while the cap on the tax exclusion would not amount to a very high tax burden in the initial years, it could affect the tax burden of individuals much more substantially in the future.

The cap on the tax exclusion probably would not have much impact on the comprehensiveness of health benefits, at least initially. An individual's preference for the level of comprehensiveness in his or her benefits would depend upon how much of the premium is subject to taxation and the impact of moving to a health plan with a lower premium on the comprehensiveness of insurance and ultimately on out-of-pocket expenses. Some individuals might equate the higher cost-sharing associated with a lower premium health plan to a tax. If it is determined that individuals prefer the certainty associated with higher premiums and more comprehensive benefits, the impact of the cap on the tax exclusion might be negligible. But over time, the impact of the cap on the tax exclusion should grow as long as insurance premium growth exceeds overall inflation, but it could be many years before the higher taxes are a large enough burden to drive people toward less comprehensive benefits.

Capping the exclusion from income also raises questions regarding how to value the benefit at the individual level. Currently, health benefits are typically valued at a community rate. Groups that are fully insured typically pay an insurer a per-person premium, with an average price that varies by employee population characteristics and health care use. Self-insured employers typically divide the total cost of the health plan by the number of covered employees to derive an average "premium equivalent." If employers were required to value health benefits for tax purposes, the current method that employers use to value premiums would be beneficial to some workers but not to others.

Under a self-insured health plan there is no premium: Employers pay claims as they are incurred. If employers had to value health benefits for tax purposes, would they value the benefit at the average, or would each worker be assigned a value corresponding with his or her actual or expected use of health care services? Is the value of health benefits lower for lower-risk individuals than it is for higher-risk individuals? If the value of the benefit is determined by health risk, higher-risk individuals would be assigned a higher value for health benefits and, all else equal, would pay higher taxes associated with the value of the benefit that is above the exclusion cap. If the value of the benefit is not associated with risk, higher-risk individuals would benefit because they would, on average, use more health care services than the average value of the benefit. The method used to determine the value of the health benefit may drive adverse selection. If the average premium was used to value the benefit, lower-risk individuals would likely opt out of the plan in order to seek less costly health insurance on their own. When lower-risk individuals leave an insurance pool,

the average cost of insurance rises for everyone who remains in the pool. This process would continue until only higher-risk individuals remained in the pool, making the insurance plan unsustainable.

Changing the tax treatment of health benefits would likely affect the design of health benefits. If preferential tax treatment is capped, employers might reduce their contributions to that level. Coverage for such items as dental care and vision care might be dropped. Employees who wish to maintain these benefits might have to pay for them with after-tax income. Employers might also shift more resources to health promotion and disease prevention programs.

Administrative burdens are also likely to increase. Plan administrators would be faced with valuing excess benefits. Employers with sites in different states could face multiple valuations because the cost of the benefit package could vary in different geographical regions.

Insurers' pricing practices must also be considered. Current underwriting practices may cause price variations for a given benefit package for employers whose work-force characteristics or group size differ. Because insurers currently can charge higher premiums for the same benefit package for groups that are older or less healthy, one firm could pay more for the standard benefit package per employee than another firm. This could translate into workers in one firm paying more taxes than workers in another firm for the same benefits. Self-insured firms pose additional considerations because they might not have available the dollar figures that correspond to a commercial insurer premium until after the employee's tax year.

Whether a cap is currently necessary is clearly a matter of debate. Currently, it can be argued that a cap is not necessary because the market is already responding to the rising cost of providing health benefits: Many employers have simply increased various forms of cost sharing, and deductibles for in-network and out-of-network preferred provider organization (PPO) and point-of-service (POS) coverage have increased (Figure 12). The percentage of employers requiring a $20 co-payment for office visits increased from 39 percent to 49 percent between 2004 and 2005 (Figure 13), and co-payments for prescription drugs, especially brand name and nonformulary drugs, have increased (Figure 14).

Employers are also starting to fundamentally restructure the financial incentives in employment-based health benefit programs by adopting so-called account-based health plans or consumer-driven health plans (CDHPs) (Fronstin, 2002 and 2004). CDHPs are essentially high-deductible health plans (HDHPs) combined with either a tax-preferred health savings account (HSA) or health reimbursement arrangement (HRA) that persons covered by the plan can use to pay for out-of-pocket costs that they incur either before they reach their deductible or after the deductible has been met. It has been estimated that 20 percent of employers are already offering some form of CDHP or HDHP, with large employers (with 5,000 or more employees) leading the way with one-third offering them (Figure 15), and that approximately 2.4 million workers were covered by an HSA or HRA plan in 2005 (Claxton, et al, 2005).[6] It is expected that in 2007 an additional 33 percent of employers will adopt a CDHP,[7] and that by 2010, CDHPs could account for 24 percent of the market.[8]

Premiums for these plans are much lower than they are for traditional plans. Various surveys have found premiums for CDHPs to be between hundreds and thousands of dollars lower than the cost of indemnity and managed care plans (Figure 16). One recent study found that the movement to CDHP generated an 8 percent reduction in medical costs.[9] As a result of these plans, cost shifting in general, and other strategies to control costs, average increases in spending on health benefits have fallen from nearly 15 percent in 2002 to 6.1 percent in 2005.[10]

Capping Individual Deduction for Health Insurance (Commission Proposal)

The Panel also recommended that individuals "outside" the employment-based health system be allowed to deduct the cost of health insurance premiums from taxable income for insurance purchased directly from an insurer. The deduction would also be limited to $5,000 for individual coverage and $11,500 for family coverage in 2006. It has been estimated that this later deduction would reduce the uninsured by 1 to 2 million people.[11]

Leveling the tax playing field has its advantages and disadvantages. Among the advantages is that it is equitable: Individuals without access to employment-based health benefits would be provided the same tax preference as individuals with a job that offers health benefits, and, as mentioned above, it would likely

reduce the uninsured by between 1 and 2 million people. Leveling the playing field also gets at the issue of affordability for individuals outside of the employment-based system.

However, there are reasons why it may not be advantageous to extend favorable tax treatment to health insurance purchased in the nongroup (individual) market. The nongroup market for insurance serves a very specific purpose: Unlike the employment-based market, where participation is very high, the individual market is driven by consumer expectations of their future health care needs. As a result of the voluntary nature of the market, individuals often seek coverage in anticipation of needing health care services, which drives up premiums for many people in that marketplace (Helms, 2005). There is also a high turnover rate because, once a person no longer needs coverage, insurance is dropped or allowed to lapse.[12] Unless there is an individual mandate (an approach recently adopted in Massachusetts), the nongroup market would not do a better job of pooling risks than the employment-based market, where groups are not formed for the purpose of purchasing health insurance.

Employers might drop coverage if individuals were able to get the same tax break in the nongroup market as they do for employment-based health benefits. In addition, if individuals leave the employment-based market for the nongroup market, employers might decide to drop coverage for their employees. Employers may also be forced to drop coverage if individuals left the employment-based market for the nongroup market. Insurers might drop employers from coverage in the small group market if enough workers switch to the individual market and small employers are unable to meet the minimum participation requirements.[13] As a result, more workers might lose coverage in the employment-based market than gain it in the nongroup market.

The nongroup market also does not benefit from employer influence over quality of health care or health care costs. So while it is equitable to extend tax-favorable status to health insurance premiums for nongroup coverage, and it may address affordability of health insurance for some people, the unanticipated consequences of expanding the nongroup market should be considered in any decision to reform the tax code as it relates to health insurance.

Substitution of the nongroup market for employment-based health benefits raises a number of questions. As reported previously, few individuals were extremely or very confident that they could chose the best available health plan in the nongroup market. In fact, the Institute of Medicine (2004a) concluded that nearly one-half of all adult Americans were health illiterate.[14] The Institute of Medicine report cited studies which determined that limited health literacy has been shown to be associated with worse health status, higher use of health care services, and worse clinical outcomes. It also found that individuals with limited health literacy and chronic illness have less knowledge of disease management than those with higher health literacy. While the report did not examine the impact of health literacy on knowledge of health insurance and purchasing decisions, the conclusions drawn from the report raise the obvious question of how well served individuals would be in the nongroup market and how long it would take for individuals and insurers to match themselves up with appropriate products.

There is also the issue of the impact on the uninsured. While premiums may be affordable for persons in good health, persons with pre-existing conditions and older individuals might not be able to afford insurance premiums in the nongroup market, since they are definitionally high-risk and therefore face very high premiums. Hadley and Reschovsky (2003) predict premiums for persons with major health problems would be about 60 percent higher than those for persons in excellent health with no chronic conditions. As a result, premiums today would range from $1,661 to $2,941 for 25-year-olds with health problems and from $5,635 to $10,230 for 60-year-olds with health problems.[15] Clearly, whether an individual gets coverage in the individual market would depend on a number of factors, a primary one being affordability of coverage.

Low-income workers would have the most difficultly affording insurance coverage in the nongroup market. In 2004, 23 percent of workers ages 25–34 and 35 percent of workers ages 55–64 earned more than $50,000 (Figure 17). In other words, 77 percent of workers ages 25–34 and 65 percent of workers ages 55–64 earned less than $50,000 a year. Research shows that individuals with income below $50,000 are more likely to need to borrow money just to cover basic living expenses (Figure 18). For example, Bureau of Labor Statistics research shows that average expenditures on food, housing, clothing, and medical care are $23,715 for families with family income of between $15,000 and $19,999. As a result, deficit spending just

based on these items ranges from $8,715 for families with $15,000 in income to $3,716 for families with $19,999 in income.

There is also the impact of an increased uninsured population on worker productivity. Employers offer health benefits as a way to invest in the health status and ultimately the productivity of their employees. The degree to which workers have health coverage affects the profitability of specific employers as well as the strength of the overall economy. According to the Institute of Medicine (2004b), the aggregate annualized cost of diminished health and shorter life spans associated with uninsured Americans is between $65 and $130 billion. Insured workers therefore contribute not just to the overall success of a business, but to the overall success of the economy.

Finally, there is also the issue of who bears the burden of the tax cap for individuals in the nongroup market. Health plan premiums tend to vary substantially with age and health status in the nongroup market. Older individuals and less healthy individuals would bear most of the additional tax burden from excess benefits even when they have the same health plan as a younger or healthier person, simply because they would pay a higher premium for the same health plan.

HSA Expansion and Tax Credits (Bush Administration Proposal)

The Bush administration is taking a different approach from the Panel toward tax incentives to drive change in the health care system. Unlike the Panel, President Bush does not propose a cap on the tax exclusion of health benefit premiums; in fact, he would not remove any of the existing tax preferences for health insurance. Instead, he has proposed a number of new provisions for the tax code to expand the use of health savings accounts (HSAs).

Under the Bush proposal, individuals would be able to deduct the full premium for a HDHP used in conjunction with an HSA even when purchased in the nongroup market directly from an insurer. As mentioned above, premiums paid toward nongroup insurance premiums are currently tax deductible only to the extent that they (and other qualified medical expenses) exceed 7.5 percent of AGI, and only the amount that exceeds 7.5 percent is deductible. To further move toward leveling the playing field between the tax treatment of health insurance in the nongroup market and the tax treatment in the employment-based market, individuals would receive a tax credit to compensate for the fact that premiums for employment-based health benefits are also not subject to Social Security and Medicare payroll taxes. Bush would also raise the contribution limits to an HSA, so that a larger amount of out-of-pocket spending under an HSA could be paid using pre-tax income.

The Bush proposal would not completely level the playing field: Individuals who purchase insurance in the nongroup market would still be subject to the 7.5 percent AGI threshold if they purchase a health plan that does not qualify them to contribute to an HSA. For instance, an individual purchasing health insurance with a deductible of less than $1,050 would not be able to fully deduct the premium from taxable income. A tax credit that could only be used for HDHPs combined with HSAs may also distort free market decisions of consumers.

The proposal also includes a tax credit that could be used toward the purchase of insurance in the nongroup market. Only families with income below $25,000 a year would be eligible for the full credit.[16] The tax credit would be limited to 90 percent of the premium and would be capped at $1,000 for individuals and $3,000 for a family of four. Unlike past tax credit proposals from the Bush administration, this proposal would allow the tax credit to be used only toward the purchase of a HDHP in conjunction with an HSA. If the entire tax credit is not used to purchase health insurance, the remaining amount of the tax credit could be contributed to an HSA.

The Bush administration has clearly put a stake in the ground for HDHPs used in conjunction with HSAs. If this proposal were enacted, it may be one of the first times that the tax code is used to give individuals an incentive to purchase a specific product, as opposed to affecting general behavior. For example, the tax code does not distinguish between size and characteristics of a home or quality of workmanship in so far as the deductibility of interest on a mortgage is concerned when someone buys a home.[17] Similarly, the tax system is indifferent with respect to the deferability of contributions to a retirement savings plan when it comes to participant investment choices. Contributions that turn out to be bad investments are treated the same way as contributions that turn out to be good investments. Under the

Bush HSA expansion proposal, HSAs would be given a tax break that other forms of health insurance would not enjoy. Furthermore, the Bush administration is sending a message to insurers and employers that HSAs are the answer to the problems in health care, so it is no longer necessary to develop innovative insurance products because they will not receive the same tax preference that HSAs receive.

While it is clear that tax credits that are low relative to premiums will do very little to help low income families, such as those portrayed in Figures 1 and 3, estimating the overall impact of a tax credit and/or deductibility of HSA premiums is fraught with uncertainty. According to Pauly and Herring (2001), "predicting the effect of credits that are large enough to matter is fraught with uncertainty, both because there are many possible designs and because the behavioral responses are properly subject to a wide range of conjecture." In their study, they find that a 50 percent tax credit would reduce the uninsured between 6 percent and 84.7 percent, with the wide range depending upon other factors. Emmons, Madly, and Woodbury (2005) also found a wide range of estimates related to the impact of a refundable tax credit on the number of uninsured and the associated government expenditures needed to expand coverage. While these studies are not specific to HSA-based plans, they do offer insight into the difficulty of predicting the impact of tax credits generally.

The Bush tax credit proposal may have a larger impact, on average, than a tax credit for all types of insurance because the average cost of a HDHP will be lower, making the tax credit higher in relation to the premium. Alternatively, a tax credit that can only be used for a HDHP-HSA plan may have less impact because uninsured individuals may not value the insurance as much if they need to pay the remaining portion of the premium and then the deductible before insurance pays for health care services.

Two recent studies have examined the impact of HSAs on the number of people with insurance coverage. Glied and Remler (2005) examined the impact that the availability of HSAs would have on coverage expansion. They conclude that HSAs are not likely to be an important contributor to expanding coverage among the uninsured because most of them do not face high enough marginal tax rates to benefit from the tax deductibility of contributions to an HSA. More recently, Gruber (2006) examined the Bush administration proposal to expand health insurance coverage, and projects that the combined Bush-proposed HSA expansion and tax credit would *increase* the number of uninsured by about 600,000 people. However, he assumes that the proposal, as it relates to the tax treatment of premiums, would cause some employers to stop offering insurance coverage to workers. This assumption may be unrealistic for a number of reasons: First, there would be no change to employers' ability to deduct the premium for health benefits as a business expense; second, employers would continue to provide coverage if they think that discontinuing the benefit would have an impact on the overall success of their business; and third, employers are generally not knowledgeable about the tax treatment of health benefits. As mentioned above, 57 percent of small employers did not know that health insurance premiums were 100 percent tax deductible to the employer. Gruber (2006) may be correct that employers drop coverage, but not because of the change in the tax treatment per se. As mentioned above, if workers leave the employment-based market for the nongroup market, employers may decide to drop coverage. Furthermore, insurers may drop coverage of small employers if enough workers switch to the individual market, because small employers are often subject to minimum participation requirements.

Full Deductibility of Health Care Expenses From Income

In stark contrast to the Panel proposal to cap the exclusion from income of premiums, and the Bush plan to expand the exclusion from income-related to HDHP premiums and HSA contributions, another recent proposal would simply increase the exclusion from *income-related* to *out-of-pocket* payments. As mentioned above, it is believed that patients overuse health care services because the tax code provides an incentive to purchase more comprehensive coverage with less cost sharing as opposed to less comprehensive coverage with more cost sharing. Cogan, Hubbard, and Kessler (2005) propose that individuals be able to deduct out-of-pocket expenses in their entirety from taxable income as a way to encourage more people to adopt less comprehensive coverage with more cost sharing. While consumers may move toward less comprehensive coverage, as long as health care expenses are tax deductible, consumers may also have a preference to overuse health care relative to other goods and services. Cogan, Hubbard, and Kessler believe that the cost savings from the movement to less comprehensive coverage would outweigh the additional spending on health care that would occur when out-of-pocket payments can be made on a pre-tax basis.

Cogan, Hubbard, and Kessler also propose modifications to HSAs. They propose to eliminate the minimum deductible needed to contribute to an HSA. They also propose reducing the maximum contribution level to $1,000 for individuals and $2,000 for families, and de-linking the contribution level from the deductible. Finally, they propose that funds in an HSA be used to purchase insurance.

It is difficult to see how these modifications would enhance their proposal to provide full deductibility from income of health care expenses. If individuals could fully deduct health care expenses from income, there would essentially be no need for an HSA. The only benefit of an HSA would be to give people an incentive to "save" money for unanticipated health care expenses, and to allow build up of the account tax free. However, if contributions to the account are limited, they would be less valuable to individuals as well.

Reduce or Eliminate Business Tax Deduction

It is often suggested that the tax deductibility of employment-based health benefits enjoyed by employers led to the rise in its prevalence. This may explain why for-profit employers provide benefits, but does not explain why not-for-profit employers, public-sector employers, and unprofitable employers also offer these benefits. These employers offer the benefits for business reasons, and often compete against for-profit employers for workers; therefore, indirectly at least, these employers offer these benefits for the same reasons that for-profit employers offer them. Were employers to voluntarily shift compensation from benefits to wages, there would be very little tax savings, as wage and benefits are also both tax deductible as a business expense. Policymakers would, however, shake up the market for health insurance by reducing or eliminating the business tax deduction for it.

If the tax deduction were capped or eliminated, employers would likely drop health benefits. There is a tipping point at which the cost of health benefits exceeds the benefits reaped by employers from offering these benefits. Changing the employer deductibility of these benefits may accelerate the time that it takes to reach that tipping point. Such a policy would give profitable for-profit companies a strong incentive to cut back or eliminate coverage. If not-for-profit companies and public-sector employers do not need to use health benefits to compete for workers, they would likely cut back or eliminate benefits as well. Government tax revenue would increase because some combination of higher employer or employee income would be taxable. However, the number of uninsured would increase (Helms, 2005), which would drive up costs associated with uncompensated care, ultimately offsetting some of the increased tax revenue.[18] Furthermore, if workers receive an increase in wages and instead of using that money to purchase health insurance shift that portion of income to other tax-preferred forms of compensation, such as a 401(k) to continue the tax/non-tax mix of compensation, current government tax revenue would not be affected.

Economic theory suggests that were employers to stop offering health benefits, employees would see a commensurate increase in wages because the amount of money that employers spend on behalf of employees for health benefits is part of a worker's total compensation. Whether, in practice, employers would increase cash wages is the subject of intense debate.

Currently, there is some evidence to support the theory that workers bear the incidence of increases in the cost of providing health benefits. Sheiner (1999), for example, used variation in health insurance costs by city to examine the age/wage earnings profile and concluded that, overall, older workers pay for health insurance costs via a flatter age/wage profile. Similarly, Gruber (1994) found that mandated maternity benefits impacted wages, but found general effects as opposed to individual-specific effects. In neither case did the researchers examine the impact that a reduction in the cost of health insurance to employers would have on employee wages. Pauly (1997) found that employers often think differently about the relationship between the cost of health insurance and worker wages, and that they usually never agree with economic theory. Recent changes to health benefit packages is a case in point: Instead of shifting the cost of health benefits back to workers in the form of wage reductions, employers are raising various forms of cost sharing, which is in effect a wage reduction via less comprehensive coverage that is only felt by workers who use health care services. Pauly (1997) cites a number of reasons why it is so difficult in practice to build in trade-offs between wages and health insurance costs. Hence, as long as employers link the cost of health benefits to profitability, the elimination of health benefits as a work-place benefit should not be expected to result in a one-to-one dollar increase in employee wage. Even if employees move to the nongroup market, if the tax treatment of those premiums were the same as the tax treatment of employment-based health benefits, rendering work-place health benefits less valuable as an employee benefit, and employers dropped those

benefits as a result, a one-to-one increase in wages may not materialize. Instead, workers may see their wages increase only by their portion of the premium.

Impact of Tax Reform on Technological Innovation

Spending on health care currently accounts for 15 percent of the U.S. economy and is expected to reach 20 percent by 2015 (Borger et al, 2006). Jobs in or related to health care include providers of health care services, individuals employed in health care facilities, insurance-related jobs, and manufacturers of health care technology. All sectors of the health care industry would be affected if fundamental tax reform reduced spending on health care services. One area in particular that deserves attention is the impact that tax reform might have on technological innovation, diffusion of new technology, the health status of the population, and, ultimately, worker productivity.

The unintended consequences of lower health care spending could have reverberating effects on current and future generations to the degree that research and development (R&D) firms in the health care industry are affected. R&D as a percentage of sales is relative high in the health care industry: In 2000, R&D as a percentage of sales was 12.8 percent in drugs in medicine, compared with 10.5 percent in computer software and services, and 3.8 percent in aerospace and defense (Meyer, 2002).

Weisbrod and LaMay (1999) raise an important question regarding the impact of cost containment on technological innovation in health care. They explore how the expectations that R&D firms have about the market for new technologies affect the projects they choose to pursue because policy decisions affecting expectations of profitability for various prospective products also affect the incentives to produce them (Weisbrod, 1991). They suggest that the ambiguities of public policy send complex signals that could affect the types of new technologies that are developed in the future. In other words, the *threat* of cost containment related to tax reform could result in manufacturers shifting capital away from health care technologies to innovations in non-health goods, and could also affect the types of R&D undertaken. And while new technology is generally costly, and accounts for anywhere between 50 percent and 66 percent of health care cost increases (Newhouse, 1992; Cutler, 1995), new technology has the potential to save life, improve the quality of life, and ultimately affect worker productivity and the bottom line for business generally.

Halvorson and Isham (2003) refer to these new technologies as miracles. They point to technology to keep premature babies alive that did not exist 10 years ago. They point to the 700,000 coronary artery stents that are used to prevent second heart attacks, and refer to prosthetic devices, transplanted organs, and various pharmaceuticals. The risk associated with reducing health care spending through tax reform (or any other means) is that technologies like these may not be developed because R&D companies may choose to invest in non-health-related sectors of the economy. While Halvorson and Isham recognize that new technology is costly and is expected to become more costly, and that society has never really been asked to make serious decisions about the overall cost of care, it has also been recognized that there are real economic benefits from technological innovation in health care.

Cutler and McClellan (2001) analyzed technological innovation to examine whether the costs or the benefits were greater. They conclude that spending on health care services as a whole is worth the increased cost of care. Other researchers have shown that advances in medical technology that have improved life expectancy have had a significant positive impact on the economy. Murphy and Topel (2000) found that improvements in life expectancy due to technological innovations in medical care added roughly $57 trillion to national wealth between 1970 and 1990, or $2.8 trillion per year (in 1992 dollars). After factoring out the cost of providing those medical services, the net benefit to the economy was $2.4 trillion per year. They conclude that the potential gains from future reductions in mortality are extremely large.

More recently, Long et al. (2006) examined the economic impact of treatment of hypertension. They conclude that treatment of hypertension resulted in 86,000 fewer premature deaths in 2001 and 833,000 fewer hospital discharges for stroke and heart attacks in 2002. In 2002, more than $16 billion in total direct medical costs were avoided due to fewer strokes and heart attacks, and the benefit-cost ratio would be even higher had the impact of hypertension drugs on productivity been examined.

One problem with justifying cost increases on a cost-benefit basis is that the benefit of a technological advance often does not take into account the effects on the economy. While some technological advances

may reduce the cost of treating a person with a specific condition (for instance, if a prescription medication could be used as a substitute for a more costly invasive procedure), most often technological advances will increase the cost of diagnosis and treatment. Employers tend to focus only on the cost of providing health care services; quantifying the magnitude of the benefit to a specific employer, as opposed to the benefit more generally to the economy, is a much more difficult task. Even though employers should be sharing the benefit of economywide growth due to technological innovation in health care, unless they are shown how health benefits improve the bottom line, most employers will view health benefits as a *cost of* doing business rather than an *investment in* their business.

Ultimately we do not know if changing the tax treatment of health benefits would have a positive or negative impact on technological innovation. On the one hand, the current system does not always do a good job of evaluating the costs and benefits of new technology: New technologies are often evaluated against the assumption of *no* technology when they should be evaluated against already *existing* technology. Therefore, cost containment through tax reform may result in more scrutiny of technological innovation, which could mean that only the most cost-effective technologies are adopted. The risk of tax reform related to health insurance is that the development of new technology may be stifled. R&D firms may not want to assume the risk associated with technology development if there is an increasing uncertainty regarding the adoption of what may turn out to be a marginally beneficial new technology.

Conclusion

Voluntarily provided employment-based health benefits are the most common source of health coverage among persons under age 65 in the United States. Many reasons have been cited regarding the causes for the growth in employment-based health benefits. The tax-preferred status of employment-based health benefits has been mentioned as one of the primary reasons for its rise in prevalence. The tax-preferred status has also been implicated in the rise in the comprehensiveness of health benefits and economic inefficiency in the health care industry. For these reasons, policymakers and others are interested in fundamentally reforming the tax treatment of health benefits.

There are a number of ways to reform the tax treatment of health benefits. The tax exclusion of premiums from employee income can be capped, as proposed by the President's Advisory Panel on Federal Tax Reform. The exclusion from income can also be eliminated. The goal of both of these proposals is to give individuals an incentive to choose or demand less comprehensive health plans. Workers may choose or demand less comprehensive health plans if they could fully deduct out-of-pocket expenses for health care services. They may also choose less comprehensive health plans if the tax treatment for HDHPs combined with a health savings account were given additional tax incentives, as envisioned by the Bush administration.

Each of these options would have a number of consequences, some intended, some not. Finally, reducing or eliminating the business deduction for health benefits would affect the number of employers offering health benefits and the comprehensiveness of the benefits being offered.

Each option to reform the tax treatment of health benefits has its advantages and disadvantages, and each raises a number of questions, such as the impact on cost containment and the number of people in the United States without health insurance. The assertion that the tax subsidy of employment-based coverage distorts the market for health insurance and therefore creates an inefficient allocation of resources is based on the assumption that the tax subsidy is the *only* reason the market for health care services is inefficient. If there are other factors preventing the health care financing and delivery system from performing optimally, however, the "theory of second best" suggests that removing the tax incentive may not increase social welfare. Since health insurance coverage produces a number of positive external societal benefits, withdrawing the current tax incentive implicitly would suggest that individuals would obtain less-than-optimal medical care. Currently, that incentive is provided through an employment-based system that has systemic efficiencies that an individual-based system would not be able to equal.

Any honest debate of overhauling the federal tax treatment of health care in the United States needs to address not just what a new system might do, but what the trade-offs and unintended consequences might be, and who would be likely to be most affected by the change.

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Endnotes

[1] See www.house.gov/jct/s-2-06.pdf.

[2] See www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf.

[3] This section was adopted from Custer (1999) and Fronstin (1999).

[4] Employers do not get a tax break on Social Security taxes for workers whose incomes are above the wage base, since the portion of their income that is above the wage base is not subject to the Social Security tax.

[5] Employee Benefit Research Institute estimates.

[6] More recent estimates suggest that nearly 3.2 million individuals (both workers and dependents) were covered by an HSA-eligible plan (a high-deductible health plan that qualifies the policyholder to make pre-tax contributions to an HSA) in January 2006. See www.healthdecisions.org/HSA/News/default.aspx?doc_id=55537.

[7] See www.watsonwyatt.com/research/resrender.asp?id=W-910&page=1.

[8] See www.ehcca.com/presentations/cdhcaudio20051013/henrickson.pdf and remarks made during Sept. 29, 2005 audioconference www.ahip.org/audio/hsasystems/.

[9] See cigna.mediaroom.com/index.php?s=press_releases&item=1013.

[10] See mercerhr.com/ushealthplansurvey.

[11] See www.taxreformpanel.gov/final-report/TaxReform_Ch5.pdf, page 82.

[12] According to Marquis et al (2005/2006), about 40 percent of persons getting coverage in the nongroup market let their policy lap within one year. The study also concluded that those who stay in the nongroup market are in poorer health than those who leave, and that those who stay in the market are disproportionately self-employed.

[13] According to the National Association of Insurance Commissioners, 45 states allow insurers to impose participation requirements in the small-group market (personal communication, April 6, 2006).

[14] Healthy literacy was defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

[15] Premiums based on Employee Benefit Research Institute calculations based on data provided by www.ehealthinsurance.com for healthy individuals in Washington, DC for various plan types adjusted for predicted premiums found by Hadley and Reschovsky (2003).

[16] The tax credit would be phased out between $15,000 and $30,000 for individuals, and between $25,000 and $60,000 for families.

[17] Taxpayers now receive preferential tax treatment for owning a hybrid car, but the tax code does not discriminate based on the type of hybrid car (ie SUV vs. compact car).

[18] The loss of insurance associated with the reduction or elimination of the tax deductibility for employers or employees may be associated with an increase in enrollment in Medicaid and/or other public assistance programs for health care services.

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