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Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?

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- ***Tax treatment of health benefits:*** This *Issue Brief* examines fundamental tax reform as it relates to employment-based health benefits and health insurance.
- ***Health benefits a big potential target for raising revenue:*** President Bush's FY 2008 budget estimates *all* employee benefits-related "tax expenditures" (government revenue foregone due to special tax treatment) will amount to $328 billion next year, or 34 percent of the $961 billion worth of total tax expenditures in the federal budget. Tax-favored employment-based *health insurance* benefits account for the largest single tax expenditure: almost 17 percent of the total amount and almost 49 percent of all employee benefits-related tax expenditures.
- ***Politics of taxes:*** Although the current Congress is expected to ignore President Bush's 2007 State of the Union proposal for fundamentally changing how health insurance is taxed, his concept is certain to survive the end of his administration. Bipartisan tax plans have been introduced in the Senate, and several 2008 presidential candidates have proposed overhauling the taxation of health benefits.
- ***Winners and losers?*** These proposals would affect those with coverage through an employer, those who purchase coverage on their own, and those who are uninsured. They include:
  → *A tax cap and employment-based benefits*—"Capping" employers' tax deductions for health coverage, and/or workers' tax exclusion for health care benefits, could mean the end of employment-based health benefits. A tax cap would mean a tax increase for some individuals, and the tax increase could be driven by health status and geography more than it is driven by the comprehensiveness of insurance.
  → *Tax caps and cost containment*—The cap on workers' tax exclusion for health insurance probably would not have much impact on the comprehensiveness of health benefits, at least initially. 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.
  → *Tax credits and the uninsured*—The ability of a tax credit to reduce the uninsured depends heavily on several key design issues, such as the size of the tax credit relative to income and income levels overall. Previous research has shown that even very generous tax credits might not be large enough for a major portion of the low-income population to buy health insurance.
- ***Impact on the uninsured:*** Estimates vary widely on how tax treatment changes would affect the level of uninsured Americans, with advocates claiming between 3–9 million fewer uninsured as a result. Even if achieved, more than 40 million individuals would still have no health insurance.

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Introduction

Under the innocent heading of "providing a standard deduction for health insurance" in his 2007 State of the Union address, President Bush proposed fundamentally changing the way in which health insurance is taxed in the United States. Although Bush's plan was deemed "dead on arrival" in the Democrat-controlled Congress, the concept is certain to outlive the end of his administration: Since the president set forth his proposal, a number of senators, and others, have jumped on board. For instance, Sens. Ron Wyden (D-OR) and Robert Bennett (R-UT) have co-sponsored legislation that, among other things, would change the way health insurance is taxed (Wyden and Bennett, 2007). Furthermore, as of this writing, the front-running Republican presidential candidate, Rudy Giuliani, has issued his own mix of tax exclusions and tax credits for individual health insurance.[1] Health coverage clearly will be a major domestic issue in the 2008 campaign. With most Democrats advocating greater direct government involvement in health coverage in the United States, most Republicans are looking to tax code changes as the major conservative alternative.

These plans have one thing in common—they would eliminate the current preferential tax treatment for employment-based health benefits (the primary way that the vast majority of working Americans obtain health insurance coverage) and replace it with a flat deduction for all taxpayers with qualifying private health insurance. The most recent data show that about 62 percent of workers and their dependents (161.7 million individuals under age 65) had some form of employment-based health benefits, while about 7 percent (17.7 million) buy insurance directly from an insurer, and 18 percent (46.5 million) were uninsured (Figures 1–2).

Proposals to change the way health insurance is taxed would affect everyone—those with coverage through an employer, those who purchase coverage on their own, and those who are uninsured—in a number of different ways. While advocates may see changing the way health insurance is taxed as part of a larger effort at comprehensive health reform, with such pending tax issues as elimination of the unpopular alternative minimum tax and scheduled expiration of the 2001 tax cuts, the fact is that policymakers are looking for new sources of revenue for a wide variety of purposes unrelated to health care.

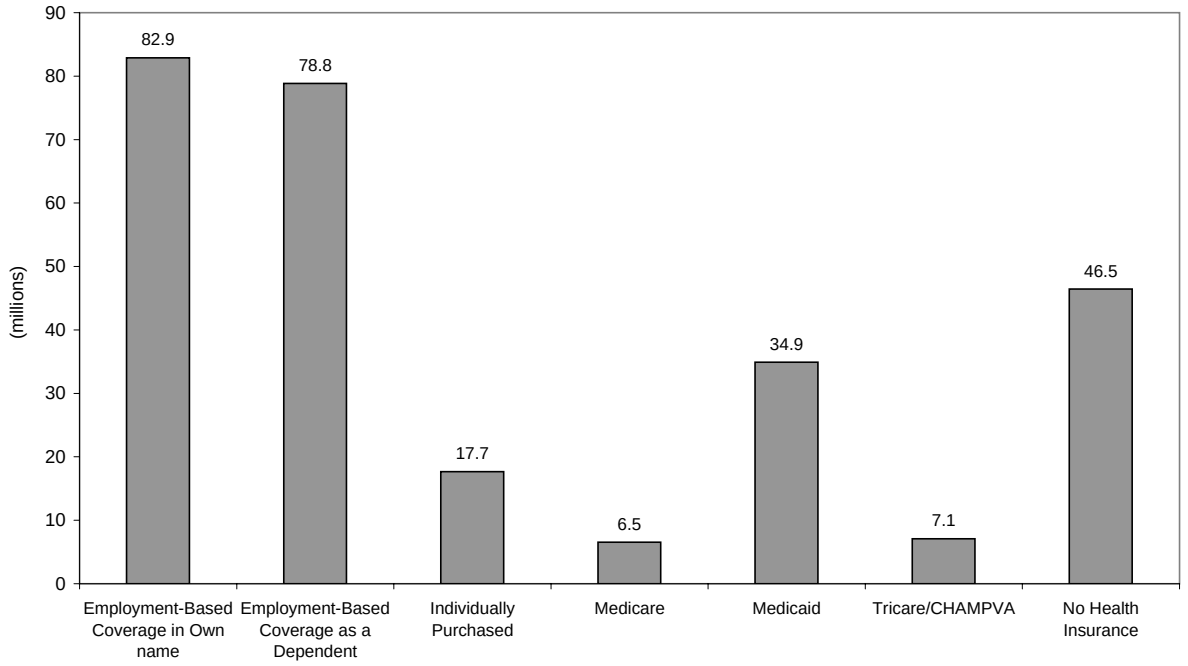
From both a budgetary and political perspective, employment-based health benefits are an almost inescapable target, as at least one estimate suggests that health care will account for $534 billion in "tax expenditures" (government revenue foregone due to special tax treatment) over the five-year period from 2006–2010 (Joint Tax Committee, 2007). President Bush's FY 2008 budget estimates that just next fiscal year, all employee benefits-related tax expenditures will amount to $328 billion, or 34 percent of the $961 billion worth of total tax expenditures in the Fiscal 2008 federal budget. Tax-favored employment-based health insurance benefits account for the largest tax expenditure presented in the budget: more than $160 billion (almost 17 percent) of the total amount and almost 49 percent of all employee benefits-related tax expenditures.

The health insurance tax proposals have far-reaching implications for employer health plan design, including the viability of many of the newest multi-tiered consumer-driven health plan designs that use a combination of flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs) to increase worker engagement and payment responsibility relative to employer payments. A reasonable planning question is whether the enactment of such tax changes in the next five or 10 years would affect what employers do or the public policies for health reform that they support during the 2007–2011 period.

While there is now bipartisan support for elimination of the current tax preference for employment-based health benefits and replacing it with a fixed standard deduction, most news coverage and analysis of the tax treatment of health insurance has focused on the Bush proposal; therefore, his proposal is the focus of this report. However, the issues discussed in this analysis relate to fundamental tax reform as it affects health insurance generally, and can be applied to other plans that already have been (and will continue to be) proposed to change the way health insurance is taxed.

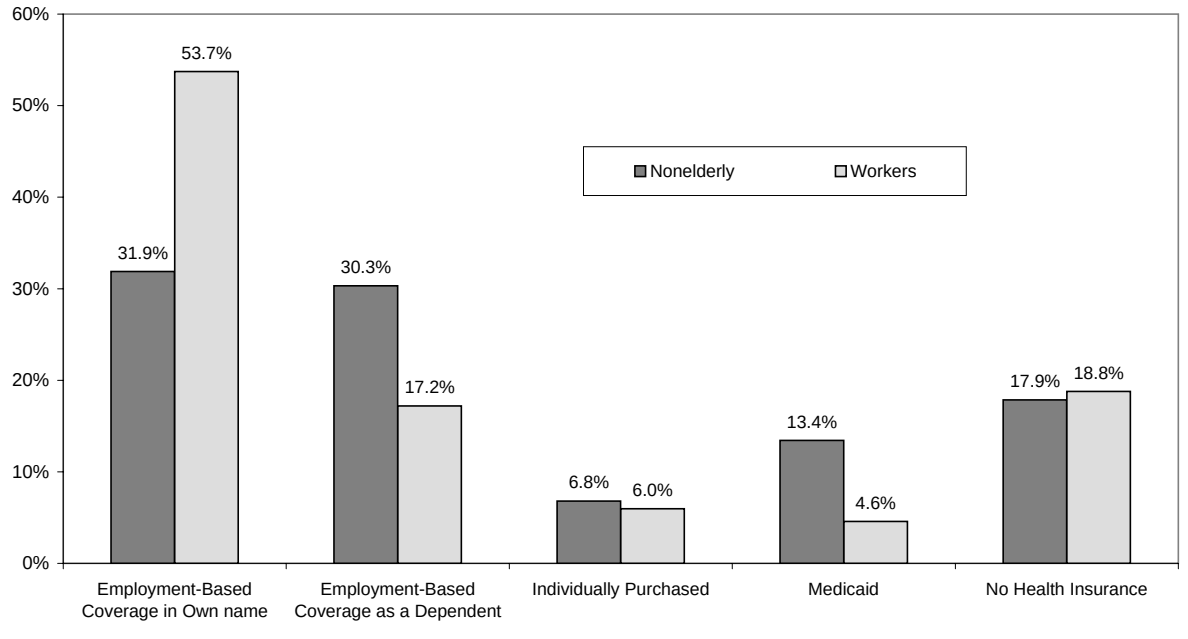
This *Issue Brief* examines fundamental tax reform as it relates to employment-based health benefits and health insurance. It focuses on the specifics of the Bush proposal, but the issues apply to the overall concept of changing the way health insurance is taxed. It summarizes the current tax treatment of health

Figure 1
Sources of Health Insurance Coverage, Persons Under Age 65, 2006



Source: Fronstin, 2007b.

Figure 2
Percentage of Population Covered by Various Sources of Health Insurance, Persons Under Age 65, 2006



Source: Fronstin, 2007b.

benefits, presents the details of changing the current tax treatment of health insurance to a standard deduction, discusses tax credits as an alternative to capping the current exclusion of health benefits from taxable income, and addresses various implications of such proposals.

Current Tax Treatment of Health Insurance

The tax treatment of health benefits has been formed 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 health insurance or health benefits on behalf of workers 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 business 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; from an income tax point of view, they should therefore be indifferent 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 Social Security payroll tax for workers whose incomes are below the Social Security wage base, which was set at $97,500 in 2007.[2] They also do not pay the 1.45 percent Medicare payroll tax for all levels of wages. Employer savings related to the Social Security and Medicare payroll tax savings accounted for about $73 billion in 2006 (Selden and Gray, 2006).

With respect to employees (including the self-employed), the amount that employers contribute toward health benefits and health insurance is generally excluded, without limit, from most workers' 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 through the FSAs, meaning they are not taxed on the amount of money that is put into these accounts. Employers can also make available a premium conversion arrangement as part of the FSA or as part of a cafeteria benefits plan, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars. Workers also do not pay income tax on employer contributions to FSAs and HRAs.

Individuals are able to deduct from their taxable income the contributions they make to an HSA if they have health insurance with a minimum deductible of at least $1,100 for individual coverage or $2,200 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a maximum $5,500 out-of-pocket limit for individual coverage, and an $11,000 limit for family coverage.[3] Deductibles can be as high as the out-of-pocket maximum, which would mean there would be no cost sharing above the deductible, although there are exceptions for plans that include benefits for out-of-network providers. 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 an annual limit of $2,850 for individual coverage and $5,650 for family coverage.[4] Persons ages 55 and older are allowed to make "catch-up" contributions as well. In 2007, an $800 catch-up contribution was allowed, and is being phased in to $1,000 by 2009.[5] 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 tax-deductible only if they exceed 7.5 percent of 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, and it is not widely used. 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.

Proposals to Change the Way Health Insurance Is Taxed

President Bush, and others, have proposed eliminating the current individual income and payroll tax exemption for employment-based health benefits. Workers would also no longer be able to exclude from taxable income their own contributions toward health benefits through a cafeteria plan or an FSA. Instead, the value of employer spending on health benefits (both premiums and contributions to FSAs and HRAs) would be reported by employers as workers' taxable income on employees' W-2 forms. The proposal would replace the current exclusion from income with a standard tax deduction of $7,500 for persons with single coverage and $15,000 for persons with family coverage (defined as any coverage that covers more than one person). It would take effect in 2009.

In terms of valuing the health benefit for tax purposes, fully insured employers could easily report health insurance premiums paid to insurers on workers' W-2 forms. Self-insured employers might face more difficult choices when it comes to valuing health benefits, or they may simply value the premium in the same way that they value health benefits for purposes of charging COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) premiums or for purposes of reporting taxable income in domestic partner situations. In fact, Joint Tax Committee staff assumes that the value of health benefits would be determined as under COBRA rules.[6] But, as discussed below, valuing health benefits is no simple task under the Bush proposal because of the particular implications of the various methods employers can choose for valuing benefits.

All persons with qualified health insurance would be eligible for the tax deduction whether their health insurance was obtained from an employer or directly from an insurer. Qualified insurance would be defined as a plan with an out-of-pocket maximum no higher than the limits set for health plans eligible for an HSA. In addition, the plans would have to have a maximum lifetime benefit of at least $700,000 and provide coverage for both inpatient and outpatient services. In the proposal, the new deduction would be indexed to overall inflation.

Individuals with qualified health insurance would be able to claim the entire $7,500 deduction for single coverage and $15,000 for family coverage regardless of the level of employer and employee spending on health benefits. For example, if the premium for single coverage was $5,000, an individual would be allowed to claim the entire $7,500 deduction on his or her tax return; but were the premium for individual coverage to exceed $7,500, an individual would be able to deduct only $7,500. Furthermore, as noted above, had that individual contributed more than $2,500 to an FSA, he or she would still have an increase in taxable income because the combination of the $5,000 premium and the contribution to an

Definitions

Tax Credit: A dollar-for-dollar reduction in the amount of tax that a taxpayer owes. Unlike tax deductions or tax exemptions, which reduce the level of income subject to tax, a credit reduces the actual amount of tax owed. There are numerous specific tax credits, such as the earned income credit, the child care credit, and the elderly or disabled tax credit.

Tax Deduction: A deduction that reduces the amount of taxable income. Perhaps the best known is the home mortgage interest deduction, which reduces an individual's or family's taxable income by the amount of interest paid each year on a home mortgage. In the case of health insurance, employers currently deduct the cost of health insurance they provide to their workers as a business expense.

Tax Exclusion: An amount of income that is excluded from calculating gross income, under a provision of the Internal Revenue Code. For instance, the value of employment-based health insurance, as currently treated by the tax code, is excluded from workers' gross income and therefore not taxed.

Tax Exemption: A tax deduction allowed because of a taxpayer's status or circumstances, rather than because of specific costs or expenses during the taxable year. For example, married couples filing joint tax returns are allowed exemptions for themselves and each of their children, which reduce the amount of income on which the couple are taxed.

FSA exceeding $2,500 would put total health spending above the proposed $7,500 standard deduction for health costs.

With respect to payroll taxes, taxable payroll would be redefined as earnings plus employer contributions to health benefits and/or health insurance, but would also be reduced by the standard deductions (either $7,500 or $15,000) for persons with health insurance. Employers would be required to adjust payroll tax withholding. Individuals who purchase health insurance directly from an insurer could ask for an exemption from payroll taxes from their employer. Individuals who overpay or underpay payroll taxes would reconcile the difference when they file their tax returns, as individuals with multiple jobs do now.

As noted, the tax advantage of FSAs would be eliminated under the proposal. Workers would no longer be allowed to contribute to an FSA on a pre-tax basis in order to pay premiums or out-of-pocket expenses. However, workers with a qualified high-deductible health plan (HDHP) would continue to be eligible to make contributions to an HSA on a pre-tax basis, and to use the money in the HSA to cover qualified medical expenses. Distributions from an HSA for qualified medical expenses would be tax free.

The tax treatment of health benefits as it affects employers would not change under the proposal: Employers would continue to be able to fully deduct the cost of providing health benefits as a business expense.

In November 2005, the President's Advisory Panel on Federal Tax Reform (Panel) released a long list of recommendations to fundamentally change the tax code. As part of the recommendations, the panel concluded that limiting the amount of health benefits that an individual could receive on a tax-preferred basis could lower overall private health spending. The panel recommended capping the exclusion of employment-based health benefits from income, as doing so also could reduce health spending.

The theory behind capping the health tax exclusion rests on the assumption that, because of the tax-preferred status of employment-based health benefits, workers prefer health benefits over cash wages—and because of this preference for health benefits, they are "over-insured" and therefore use more health care services than they otherwise would. The theory holds that workers:

> (1) Over-insure because health insurance premiums are not included in taxable income, but out-of-pocket spending on health care services is usually not deductible from taxable income. As a result:
> (2) Workers prefer comprehensive insurance with low cost-sharing. Ultimately, it is argued that
> (3) Low cost-sharing, or the ability to pay out-of-pocket spending with pre-tax dollars, leads to overuse of health care services, which drives up insurance premiums and makes insurance less affordable, especially for lower-income workers.

Capping the exclusion from income, the theory holds, would mean that workers and employers would start to offer health benefit packages below the level of the cap in order to avoid paying taxes on excess health benefits. The primary benefit, advocates say, would be in reducing unnecessary health care costs.

According to the Bush administration and others, the purpose of eliminating contributions to FSAs is to "level the playing field" with respect to taxes regarding spending on health care services and spending on other goods and services. It has been argued by some economists that the current tax exclusion on out-of-pocket spending through an FSA gives workers an incentive to spend money on health care services at the expense of other goods and services. FSAs may also encourage overuse of health care services because of the use-it-or-use-it rule that requires workers to forfeit any funds not spent by year-end.

However, the administration does not point out that the tax playing field would be completely level if the tax preference for contributions to an HSA were removed as well, so that out-of-pocket spending on health care services would never be permitted on a pre-tax basis. Analysts have noted that allowing pre-tax contributions to an HSA tilts the playing field toward high-deductible health plans at the expense of other types of health insurance that may be just as effective in controlling health care use and costs.

Because the Bush proposal does not address individual insurance market reform, high-risk individuals would continue to be unable either to get insurance or afford insurance in the individual market. The administration proposes to assist states by providing funding for states to design their own programs to expand health insurance coverage for low-income and hard-to-insure populations. The Bush initiative is in large part silent regarding the details of this portion of the proposal.

The CareFirst BlueCross Blue Shield Web site (www.carefirst.com) was used to determine what small employers' workers would have to pay in the individual market for coverage that would be most similar to

that offered by small groups, assuming they wanted a guaranteed issue policy with no underwriting that could lead to pre-existing condition exclusions. This was done for a young 25-year-old and a 57-year-old. In the case of the 25-year-old, the annual premium would run between $4,200 and $5,040, while the annual premium for the 57-year-old would be between $8,535 and $10,242. In both cases, the premium is above the average premium for employee-only coverage in Washington, DC, of about $4,200 a year for HMO coverage. The 25-year-old might see tax savings by moving to the individual market because he or she would pay at most $5,040, but under the Bush proposal would realize a $7,500 deduction. Savings would depend upon overall income and tax rates. The 57-year-old would likely see his or her taxes increase because the premium would be well above the $7,500 tax cap level.

Advantages and Disadvantages of the Tax Proposal

Employment-based health benefits are by far the most common source of health insurance in the United States. In 2006, 71 percent of workers had employment-based health benefits, while 62.2 percent of the entire population under age 65 had them (calculated from Figure 2). This system, however, does not come without its pitfalls. More than 46 million individuals under age 65 were uninsured in 2006 (Fronstin, 2007b). The cost of providing health benefits has recently been increasing at twice the rate of inflation and worker earnings (Figure 3), fewer small employers are offering health benefits than 10 years ago (Claxton, et al., 2006), and Americans often do not receive recommended health care services (Asch, et al., 2006).

The Bush proposal comes with a number of advantages and disadvantages as it affects employment-based health benefits, as well as unanswered questions about the financing and delivery of health care services. These issues are discussed below.

Among the Advantages

- *De-links Health Insurance from Employment*—As mentioned above, while there are a number of advantages to an employment-based health insurance system, there are also a number of shortcomings. De-linking health insurance from employment may address those shortcomings. For example, health insurance is not portable from job to job, i.e., workers cannot usually continue to participate in their health plan when they change jobs. It has been shown that workers sometimes stay in their jobs because of health insurance. In 2004, 27 percent of adults reported that they or an immediate family member had passed up a job opportunity or stayed in a job they would have otherwise left to maintain health insurance (Helman and Fronstin, 2004). The Health Insurance Portability and Accountability Act (HIPAA) addressed portability when it comes to coverage for pre-existing conditions for workers changing jobs; however, potential employers may not offer health benefits, the benefits offered may be less comprehensive than was offered in the current job, and the benefits from the potential employer may cost more.

  Another example regarding de-linking health insurance from employment relates to the lack of choice of a health plan among workers with employment-based coverage: Workers do not have a lot of plan choices through the employment-based system. Roughly one-half of workers with health insurance are employed by a firm that offers more than one choice of health plan (Kaiser Family Foundation, 2006),[7] although this does not necessarily translate into a choice of plans for workers. When workers do have a choice of health plan, it is typically between a health maintenance organization (HMO) and a preferred provider organization (PPO) from the same insurance carrier (or through the same self-insured employer), but consumer-driven health plans are being increasingly added as an option.

  Equalizing the tax treatment between the employment-based market and the individual market does not necessarily increase choice of health plans because workers can *currently* purchase insurance in the individual market. However, equalizing the tax treatment would indirectly increase choice by making insurance in the individual market more affordable relative to the employment-based market. Insurers might start to offer a more diverse choice of health plans in the individual market to attract new business and to address increased demand.

Increased choice should not be equated with increased competition. The insurance market has consolidated in recent years, and there is no guarantee that new insurers will enter the market. Increased *choice* may simply mean that individuals have more plans to choose from; *competition* among insurers may not increase.

- *Cost Containment*—As mentioned above, insurance premiums paid by employers on behalf of workers are excluded without limit from worker income, and worker payments toward employment-based health benefits are generally excluded from taxable income as well. Proposals to change the way health insurance is taxed would limit the exclusion from income. President Bush recommends that, starting in 2009, the exclusion be limited to $7,500 for employee-only coverage, and $15,000 for family coverage, where family coverage is defined as any plan covering more than one person in a family. In 2006, the average annual premium for employee-only coverage was $4,242, and $11,480 for family coverage (Claxton, et al., 2006). By 2009, assuming premiums continue to increase at an average annual rate of 7.7 percent as they did in 2006, the average premium for employee-only coverage will be $5,299, and the average family premium will be $14,341. The administration estimates that about 20 percent of policies offered (not individuals covered) will be above the respective $7,500 and $15,000 caps. The administration does not estimate the number of individuals who would be above the cap, or take into account the number who would be above the cap if their expected contributions to FSAs were considered.

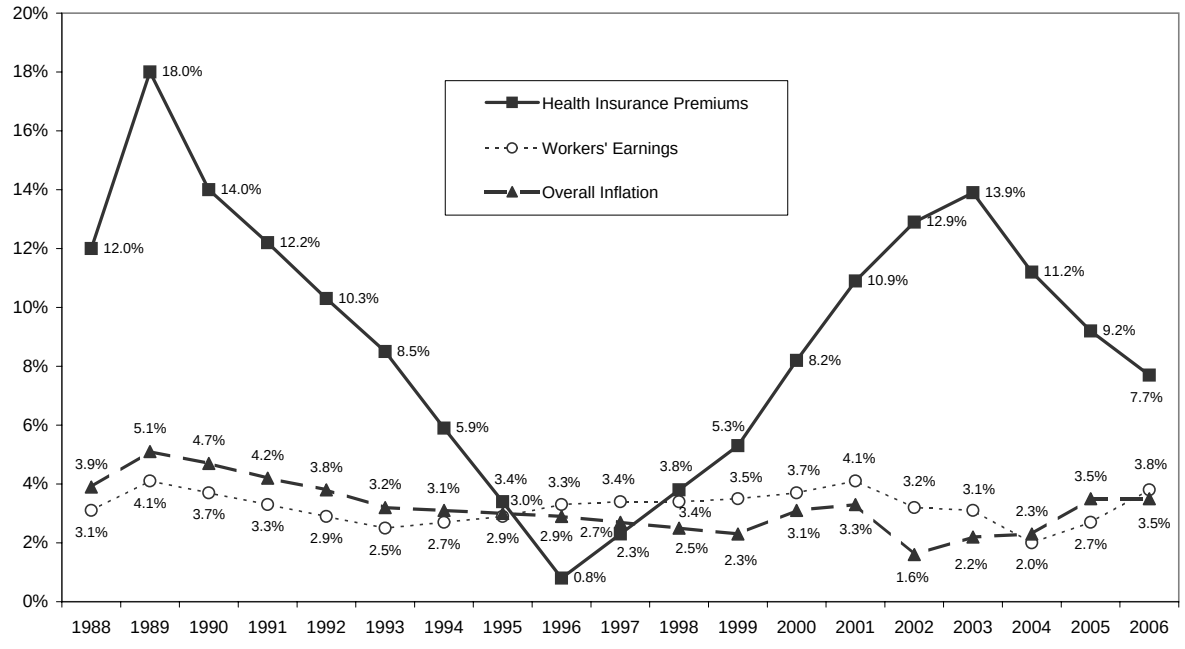
  The goal of the cap is ultimately to limit the growth of health spending and then health insurance premiums. Health care costs and health insurance premiums have been increasing faster than inflation for many years. In 2006, health insurance premiums increased at twice the rate of inflation, and as recently as 2003, health insurance premiums increased at 4.6 times the rate of inflation (Figure 3). However, under the Bush plan, the growth rate of the cap on the deductibility of health insurance premiums would be limited to the overall rate of inflation. As a result, over time, an increasing number of people would be subject to the tax cap, which in turn means that more individuals would be subject to paying income tax on the portion of the premium above the tax cap. As an increasing number of people are subject to the cap, the Bush administration argues that they expect them to reduce their insurance coverage in order to avoid paying higher taxes.

  Changing insurance coverage to reduce premiums below the cap would be easy for some people and difficult for others. Some workers would have a choice of plan, and employers could facilitate lower premiums by reducing benefits to a level that coincides with the cap. Some workers might not have a choice of plan and their employers might not make any changes because the tax burden would fall on the employee.

  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 view the higher cost sharing associated with a lower premium health plan as 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. 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.

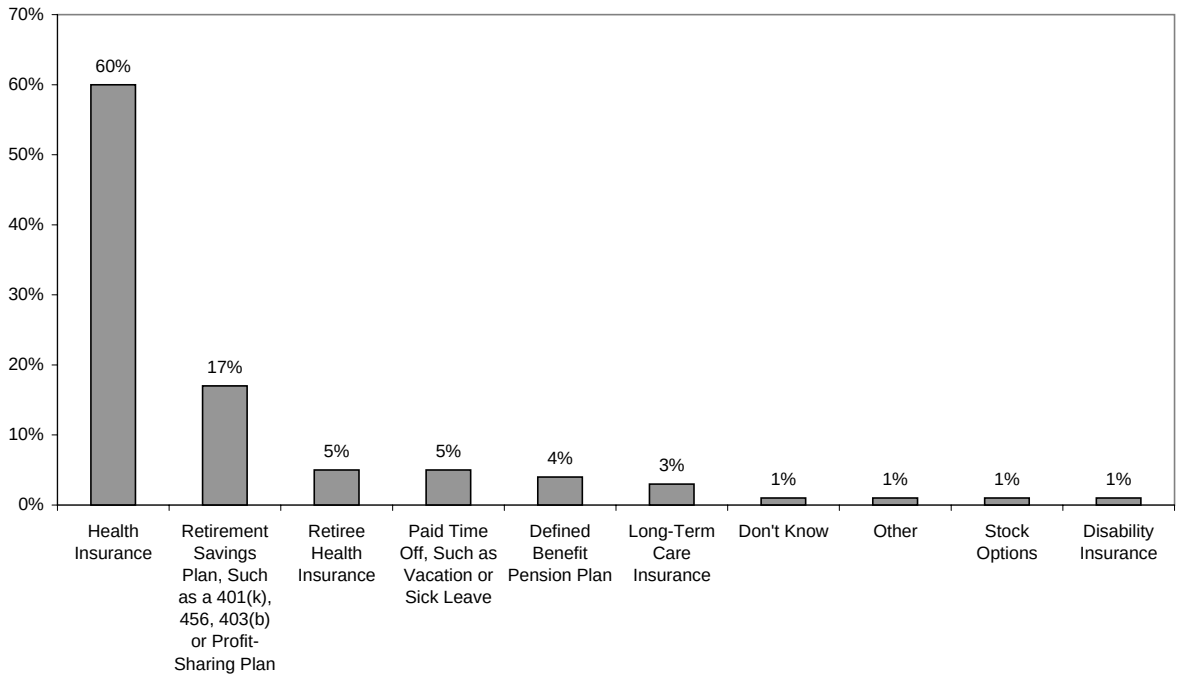
- *Instant Tax Relief*—The proposal to change the way health insurance is taxed would mean instant tax relief for a number of different groups. Currently, individuals who are not self-employed and who purchase health insurance directly from an insurer generally are not able to exclude health insurance premiums and out-of-pocket expenses from income tax. Individuals are able to deduct qualified medical expenses (which include premiums and out-of-pocket expenses) from taxable income if the qualified medical expenses exceed 7.5 percent of AGI, but only the amount above 7.5 percent of AGI is deductible from income and it is deductible only if the taxpayer itemizes his or her deductions. The proposal would extend the deductibility of health insurance to coverage purchased directly from an insurer, but limit the deductibility to the $7,500 and $15,000 caps mentioned above. In 2006, there were 17.7 million

Figure 3
Annual Increases in Health Insurance Premiums, Worker Earnings and Overall Inflation, 1988–2006



Source: Kaiser Family Foundation, Health Research and Educational Trust, 2006.

Figure 4
Most Important Benefit Among Workers Ages 18–64, 2004



Source: Helman and Fronstin, 2004.

individuals (including both adults and children) covered by health insurance that they purchased directly from an insurer (Figure 1).

Workers with coverage that would be valued below the tax cap in 2009 (when the plan has been proposed to take effect) and would not have had FSA contributions in the absence of the cap, would also get additional tax relief. As discussed above, anyone with qualified health insurance would be able to deduct $7,500 for individual coverage and $15,000 for family coverage regardless of how much money was spent on insurance premiums.

Individuals with COBRA coverage would also get a tax exclusion on their premiums for the first time, up to the proposed new standard deduction limit. The continuation-of-coverage provision of COBRA requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct. Historical data suggest that about 5 million adults are covered by COBRA during any given year (Fronstin, 1998). While COBRA beneficiaries are able to continue to be covered by a former employer's health plan, they are required to pay the full premium plus a 2 percent administrative fee. COBRA beneficiaries must currently pay their premiums on an after-tax basis. Under the proposal, COBRA beneficiaries would get instant tax relief. Tax relief for COBRA premiums could result in a larger number of individuals taking COBRA when it is available.

Retirees are another group that would receive immediate tax relief on the portion of premiums that they pay, but they might pay higher taxes if employers are providing health benefits and the value of those benefits is above the tax cap. Besides retirees who purchase insurance directly from an insurance company, retirees who pay all or part of the costs associated with health benefits from a former employer would be able to deduct the cost of that coverage, subject to the tax caps, from their taxable income. In 2006, 1.7 million individuals ages 55–64 reported that they were not working because they were retired and had health insurance through an employer in their own name (Fronstin, 2007a). An additional 400,000 reported that they were not working because they were ill or disabled and had health insurance through an employer in their own name.[8] Despite the fact that these retirees get coverage through a former employer, unlike active workers they are not able to pay their premiums with pre-tax dollars. Employers may be required to report the value of subsidized health benefits for any retirees who receive such benefits, and retirees may be required to report the value of retiree health benefits as taxable income.

Among the Disadvantages

- *Dysfunctional Individual Insurance Market*—In 2006, 17.7 million individuals were covered by health insurance that was purchased directly from an insurer (Fronstin, 2007b). Were the president's proposal to change the way health insurance is taxed to be enacted, an increasing number of individuals would likely be covered directly by insurers.

  Individuals in this market are generally *underwritten*—meaning, insurers use a process of determining whether to provide coverage for an applicant and the level of coverage in determining the appropriate premium. Insurers use underwriting to mitigate against adverse selection, a phenomenon that occurs because people with higher than average expected health care use are more likely than healthy people to seek health insurance. Insurers use underwriting to protect themselves and the lives of those they already insure. One goal of underwriting is to mitigate against individuals waiting until they become sick to apply for health insurance.

  As a result of the underwriting process, the individual insurance market is often a user-unfriendly market: Individuals are sometimes denied insurance coverage because of pre-existing conditions or coverage for those pre-existing conditions are excluded. Individuals with pre-existing conditions and/or risk factors are also often charged much higher premiums than persons without pre-existing conditions or risk factors. Unlike the group-based market, where all employees are eligible for coverage and pre-existing conditions are generally not excluded, moving workers into the individual market would create both winners and losers.

  Individuals can often purchase individual policies without underwriting, but at much higher premiums. According to the premium quotes obtained from www.carefirst.com, a 50-year-old individual in the District of Columbia can expect to pay either 25 percent or 50 percent above the best premium after the medical underwriting process is taken into account.

- *De-links Health Insurance From Employment*—While de-linking health insurance from employment has its benefits, as discussed above, there are also a number of disadvantages. The remainder of this section discusses four advantages that the employment-based system provides over an individual system: the treatment of adverse selection, group purchasing efficiencies, advocacy, and innovation and quality.

  As mentioned above, adverse selection exists when a disproportionate number of unhealthy individuals are enrolled in a specific health plan. In other words, a health plan may suffer from adverse selection when unhealthy individuals are more likely than healthy individuals to enroll in the plan. In order to reduce adverse selection, insurers often seek to sign up *groups* of individuals rather than the individuals themselves, as they often get the good risks with the bad risks.

  When it comes to insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. In a purely voluntary system, such as the U.S. system, the risk of adverse selection is relatively high because those most likely to seek insurance for health care are also those most likely to need health care. As a result, when insuring groups, insurers are unable to single out higher-risk or unhealthy individuals, allowing those individuals the same opportunity to be covered by a health insurance plan. Hence, employment-based health insurance is a potent means for spreading risk among both healthy and unhealthy individuals.

- *Group Purchasing Efficiencies*—The existence of economies of scale in the purchase of group health insurance coverage results in a lower average premium. When economies of scale exist, the average administrative costs of insuring a group make up a smaller percentage of the cost of health insurance. As a result, large firms, which are able to exert market power, are more likely to offer health benefits than small firms because they can purchase the same plan at a lower cost. In addition, employers may be better at searching or negotiating for lower cost health plans than workers would be in the individual market. Employment-based health insurance also benefits employers because it can reduce quit rates and turnover costs, especially during periods when workers highly value these benefits (Figure 4).

- *Employer as Advocate*—Employers are not only able to find or negotiate lower health insurance costs than workers could in the individual market, but they also often act as an advocate for workers during coverage disputes between the insured and insurer. For example, an employer experiencing widespread dissatisfaction with a specific health plan will either find a new health plan or threaten to find a new health plan if the insurer does not respond to the issues brought up by members of the plan. Insurers are more likely to respond to an employer than to an individual because of the risk of losing a large group contract when that group is not adversely selected.

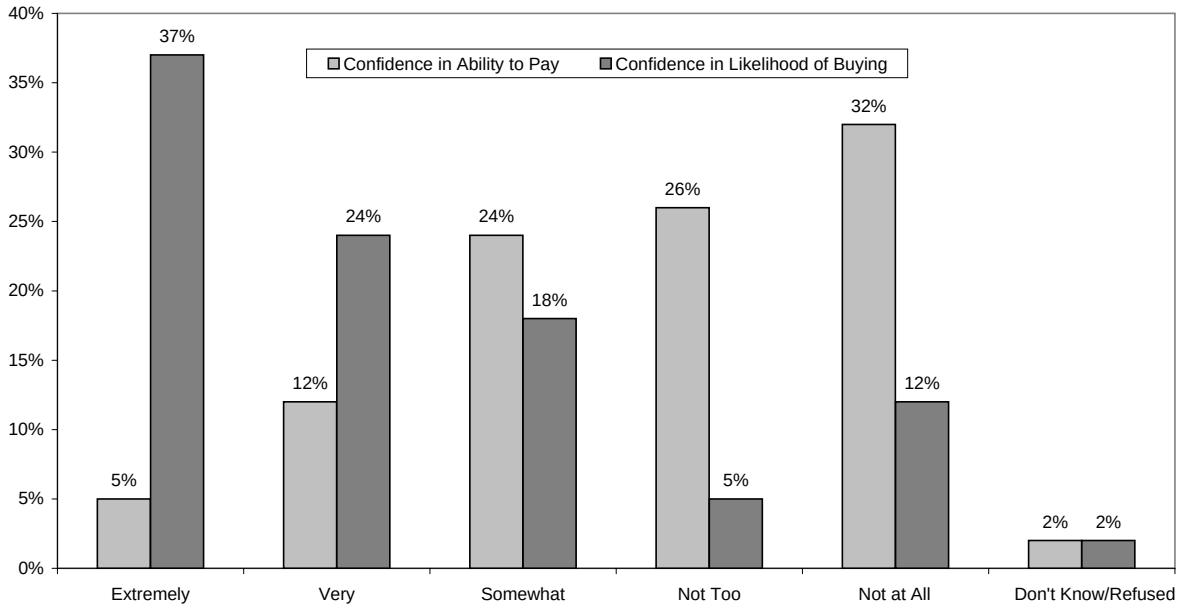
- *Delivery Innovation and Health Care Quality*—Employers frequently involve themselves in matters of quality assessment of care and influencing health care matters in the policy development arena. With the rise of health care costs in the 1970s and 1980s, large employers began to pay closer attention to health care quality. One aspect of this increased attention was the formation of coalitions of employers to facilitate the sharing of information about health care quality and health care providers among a group of employers in order to allow employers to contract with the best insurers and providers. Many believe that employers are better able to perform the role of monitoring quality of health care than individuals.

- *Reduction of Total Labor Costs Through Better Employee Health and Fewer Lost Employee Workdays Due to Illness*—Employer provision of health insurance and payment of full or partial premiums leads far more workers to have health insurance than would purchase that insurance on their own in a voluntary system. Studies for companies such as Marriott have found significant "presenteeism" benefits as a result of health insurance being provided. EBRI surveys have found that as many as one-third of workers say that they might choose to go without insurance if their employer simply increased their salary in lieu of health insurance (Figure 5). Employers that pay more than 90 percent of the premium generate an 88 percent take-up rate among workers, but those that pay nearly two-thirds of the premium

Figure 5

Individuals' Confidence in Ability to Afford Health Insurance and Confidence That They Would Buy Insurance in Nongroup Market

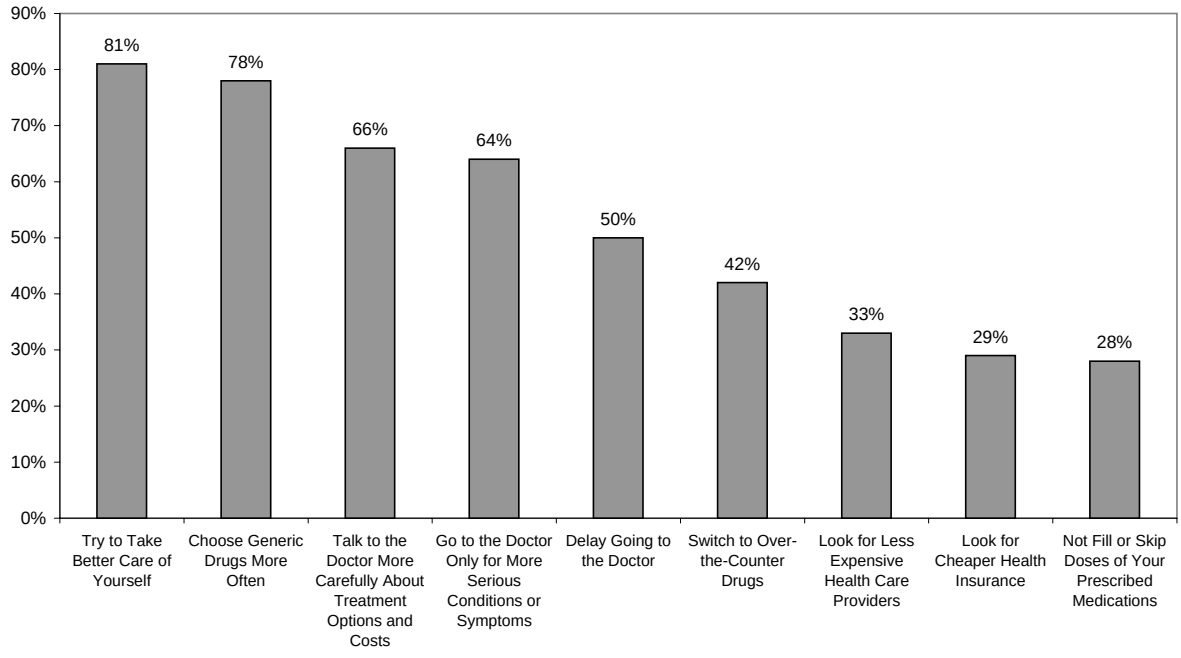
(Assumes Employer Gives Cash to Workers and Employer Drops Coverage)



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2004 Health Confidence Survey.

Figure 6

Changes in Health Care Use Resulting From Cost Increases, Among Those With Health Coverage, 2007



Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 2007 Health Confidence Survey.

see a take-up rate of only 68 percent.[9] For instance, EBRI pays 100 percent of the employee-only premium, for example, to assure that no worker even has the option of going without health insurance protection. This assures not only paid access to health care but also that employees will not find themselves in bankruptcy due to unanticipated health expenses.

Issues With the Tax Cap

As mentioned above, there are a number of possible advantages and disadvantages with capping the exclusion of health insurance premiums from income and extending the tax exclusion to the individual market. The remainder of this report discusses issues that policymakers and the private sector will need to address when implementing and reacting to a tax cap.

Issues Related to the End of Employment-Based Coverage

A tax cap could mean the end of employment-based health benefits. If the tax exclusion from income were capped, employers might respond by offering less comprehensive health benefits in order to bring the premium down to or below the cap. Because employment-based health benefits tend to be community-rated, individuals with coverage in the nongroup market are experience-rated, and individuals in the nongroup market could take the full $7,500 deduction from income even if their health insurance premiums were below $7,500, workers who could get employee-only coverage for less than $7,500 in the nongroup market would have an incentive to either 1) demand that employers provide them a cash wage increase equal to the value of health benefits, or 2) seek jobs that offer higher wages instead of health benefits, so that they could purchase health insurance directly from an insurer.

Presumably, workers seeking these options would be young and/or healthy because premiums in the nongroup market would be below average for these individuals and therefore below $7,500. As a result, these workers would realize a relatively large tax cut and would therefore find health insurance in the nongroup market more affordable than employment-based health benefits. This would be particularly true if individuals move from comprehensive health insurance to the lowest possible cost policy in the market that would still allow them to qualify for the standard deduction. This could lead to a substantial increase in the number of so-called "underinsured" individuals.

Insurers might respond to the tax cap by designing health plans to attract the young and/or healthy and the uninsured. They might advertise the fact that certain health plans will be "free," in the sense that the reduction in taxes would cover or more than cover the premium. The availability of these plans would be a draw to young and healthy workers with employment-based health benefits.

In 2006, a single worker paid, on average, $627 in annual payroll deductions for employee-only coverage,[10] while their employers, on average, contributed $3,615. A young worker earning $25,000 would save nearly $2,100 in taxes if he or she purchased health insurance directly from an insurer. This tax savings would be more than enough to cover the premiums for a high-deductible health plan or an HMO for a woman in her mid-20s in Washington, DC, where annual premiums range from about $700 to $1,400. If young workers leave employment-based health benefits for the individual market, the employment-based system would suffer from adverse selection that pushes up the cost of the employment-based coverage, thereby causing employers to rethink their role in providing health benefits.

To the degree that young and healthy workers are able to, and do in fact, leave the employment-based system, workers remaining in the employment-based system would be disproportionately older and unhealthy, which would drive up premiums in the employment-based system.[11] The employment-based system would then be in a vicious cycle: As premiums increase, the youngest/healthiest workers would move to the nongroup market, leaving relatively older/less healthy workers in the employment-based system, which would continue to drive up premiums for employer coverage. This phenomenon is known as the "death spiral" because it means the death of employment-based health benefits as a result of continued and increased adverse selection.

Employers could thus contribute to the end of employment-based health benefits that they would prefer to maintain, or would have maintained in the absence of such policy changes, in a number of ways:

- First, employers could react to the tax cap by cutting health benefits. If employers cut back on health benefits by moving to less comprehensive coverage, some workers would value those benefits less than they had in the past. This could contribute to fewer workers demanding health benefits through work, and employers could respond to this lack of demand by dropping benefits.
- Second, as workers leave the employment-based system for the nongroup market and drive up premiums in the employment-based system, employers would find coverage less and less affordable and would eventually drop that coverage.
- Third, employers are already concerned about the rising cost of health benefits, and some are looking for an excuse to drop those benefits (Christensen et al., 2002). Equalizing the tax treatment of employment-based health benefits and nongroup insurance may be the excuse employers use to drop health benefits altogether. Small employers would likely be the first to drop benefits because they struggle with affordability more than large employers. However, large employers have also been struggling with the cost of health benefits, and while they are generally hesitant to drop benefits if their workers would have a difficult time getting coverage in the nongroup market, employers are always looking for a competitive edge, and it only takes one large employer to drop health benefits in order to trigger a movement of other large employers away from these benefits.

Employers could drop benefits because of the additional administrative costs related to valuing the benefit. Under the Bush tax proposal, employers would be required to value health benefits and report the value of health benefits as imputed income. While the details of how employers would be able to value health benefits would likely be worked out in regulations, employers might have some choices to make when it comes to valuation, and these choices would likely affect workers and the value they place on employment-based health benefits.

Employers provide health benefits either by purchasing a fully insured health plan from an insurer or by self-insuring. 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." This premium equivalent is used to determine COBRA premiums in a self-insured setting. If employers were required to value health benefits for employee income and tax purposes, the current method that employers use to value premiums would be beneficial to some workers but not to others.

It is clear from employer experience with COBRA that the method used to value premiums benefits some workers and penalizes others. Employers are allowed to require that COBRA beneficiaries pay 102 percent of the premium for COBRA coverage. Because workers are generally required to pay the full premium on an after-tax basis (as opposed to paying a portion of the premium on a pre-tax basis while at work), there is a self-selection issue regarding who takes COBRA: Employers have found that COBRA beneficiaries incur, on average, about 50 percent more health care expenses than the average population of insured workers.[12] This self-selection occurs because COBRA beneficiaries tend to be older, less healthy workers who continue coverage because COBRA premiums (even at 102 percent on an after-tax basis) are more affordable than premiums for comparable insurance in the nongroup market.

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 COBRA equivalent premium, 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 benefits that is above the exclusion cap. If the value of the benefit is not associated with risk, but instead valued at the community rate, 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 is 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. As mentioned above, when lower-risk individuals leave the insurance pool, the average cost of insurance rises for everyone who remains in the pool. The process would continue until only higher-risk individuals remained in the pool, making the insurance plan unsustainable.

Valuing the benefit would also be complicated for employers operating in multiple locations. Employers with sites in different states could face multiple valuations because the cost of the benefit package could vary in different geographical regions for a number of reasons. The underlying prices for health care services could be higher in one part of the country than in another, or demographic differences in different parts of the country for the same employer could affect the valuation of health benefits.

Higher Taxes

Under the tax cap proposal, workers with health benefits valued above the tax cap would see an instant tax increase. The goal in requiring workers with so-called "Cadillac health plans" with premiums and pre-tax or tax-excluded contributions above the tax cap is to get them to purchase less comprehensive or more restrictive coverage in order to bring down the premium and other pre-tax health spending, which would be assumed to coincide with less use or more appropriate use of health care services. While the tax cap could have an impact on the number of people covered by Cadillac plans, it could also affect individuals for reasons that may be beyond their control.

Individuals' premiums may be over the tax cap not because of the *comprehensiveness of their insurance*, but instead because of the *composition of their group*. Insurers can and often do charge higher premiums for the same benefits package to groups with higher-than-expected expenses than to groups with lower-than-expected expenses. This could translate into workers in one firm paying higher taxes because their premium is above the tax cap simply because workers employed in that firm were less healthy than the average group. Hence, two workers in the same industry, in the same city, with the same health benefits could pay different taxes on the benefits (with one incurring a tax hike and the other a tax cut) simply because of their health status or the health status of the workers at their firms.

Workers would also incur different taxes because of their geographic region. Workers in certain parts of the country might be more likely than workers in other parts of the country to be above the tax cap simply because the cost of insurance varies with region. In fact, it might be found that within an employer organization that offers the same health benefits to all workers, some workers are above the tax cap simply because they live and work in a state with relatively high premiums, while other workers are below the tax cap simply because they live and work in a state with relatively low premiums.

In summary, while the number of so-called "Cadillac" plans may decline, workers could incur additional taxes simply because of the health status of the population of the workers in their pool or because of the geographic region where they live.

Would the Tax Cap Be Effective in Cost Containment?

Under the tax cap proposal, the cap on the new standard deduction for health insurance would grow over time, but it would be indexed to overall inflation. Individuals would have an incentive to seek health insurance with premiums below the cap to avoid paying a higher tax. This could lower the cost of insurance and moderate insurance premium increases; however, it also could increase premiums if the number of uninsured uncompensated care increases, and if inefficiencies in the health system are exacerbated. If health insurance premiums continue to increase at two to three times the rate of overall inflation, more individuals would be subject to paying income tax on the portion of the premium above the 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 may 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 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 with 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 or might actually increase employee demand for comprehensive employer health benefits.

Over time, the impact of the cap on the tax exclusion should grow as long as insurance premium growth exceeds overall inflation; however, it could be many years before the higher taxes are a large enough burden to drive people toward less comprehensive benefits. The Bush administration has estimated that about 20 percent of the policies offered by employers would be above the tax cap in 2009, but does not estimate the number of people in those plans. It also assumes that the comprehensiveness of health benefits does not change in response to the cap, which would lead to higher tax revenue in the future. One estimate suggests that 48 percent of tax filers would see a reduction in taxes in 2009, while 17 percent would experience a tax decrease.[13]

Would the Tax Cap Be Effective in Health Promotion and Disease Prevention?

One of the ultimate goals in capping the health insurance exclusion from taxable income is to control the increasing cost of providing health insurance. Taxing excess health insurance is expected to result in more individuals with less comprehensive coverage. In other words, the percentage of insured individuals with higher cost sharing than they currently have would be expected to increase. Deductibles could increase. Co-payments for office visits and prescription drugs could increase. And co-insurance rates could increase. Higher cost sharing should translate into lower utilization of health care services. This might—or might not—bring down overall utilization and the overall cost of providing health care services.

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 poor people 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 how cost sharing affects health status.

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 be regarded as negative. Nearly 80 percent say the increased cost of health care has led them to use generic drugs when available, and 81 percent report they now try to take better care of themselves (Figure 6). About two-thirds say cost increases have led them to talk to the doctor more carefully about treatment options and costs and say they now go to the doctor only for more serious conditions or symptoms. One-half have delayed going to the doctor. Less frequent responses to the increase in health care costs include switching to over-the-counter drugs (42 percent), looking for less expensive health care providers (33 percent), and looking for cheaper health insurance (29 percent). However, and alarmingly, 28 percent report cost increases have caused them not to take their prescribed medication.

The issue of missed care and ultimately the impact of missed care on health status may become more severe as individuals move toward consumer-driven health plans (CDHPs). One version of a CDHP (a high-deductible health plan with an HSA) may receive preferential tax treatment not enjoyed by other types of plans, which would give individuals an incentive to join CDHPs with an HSA over other plans. Prior research has found that individuals with CDHPs and those eligible for HSAs were more likely than those with more comprehensive insurance to report that they delayed or avoided needed health care because of the cost of care (Fronstin and Collins, 2006).

In fact, an increasing number of studies are concluding that increased cost sharing may result in higher health care costs and declining health status among populations with very specific diseases. 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.

These results are important because there is other evidence that increased cost sharing for prescription drugs reduces compliance with treatment regimens and increases overall spending. Goldman et al. (2006) found that compliance with cholesterol-lowering therapy dropped by 6–10 percentage points when co-payments increased from $10 to $20. They then simulated the impact of eliminating co-payments for cholesterol-lowering therapy for medium- and high-risk patients and found that nearly 80,000 hospitalizations would be averted annually, with total annual savings of more than $1 billion.

Similarly, Cranor et al. (2003) reported on the results of an educational program for persons with diabetes. It was found that educational interventions, combined with no cost sharing for diabetes-related drugs and supplies, increased compliance with treatment regimens, increased the number of patients with optimal A1c values, and reduced total mean direct medical costs by $1,200 annually per patient with diabetes. Furthermore, the introduction of the program was found to have an immediate impact on productivity. One employer found that the average number of sick days among persons with diabetes fell from 12.6 in the baseline year to about six days in the second year and remained at about six days per year for another four years.

And recently, the Integrated Benefit Institute found that increasing the co-payment by $20 for the treatment of rheumatoid arthritis reduced the proportion of individuals using prescription drugs to delay progression of the disease by 35 percent.[14] Furthermore, the study found that the proportion of those taking symptom-relieving drugs fell 84 percent. The incidence of disability among this population increased 36 percent.

Choice of Plan

While workers with health insurance premiums above the tax cap would have an incentive to sign up for less costly health plans, many workers would not have the option of making such a change unless they leave the employment-based system. Small employers that offer health benefits generally do not offer a choice of health plans. Nearly 34 percent of workers with employment-based health benefits are either self-employed or work for a firm with fewer than 100 employees (Fronstin, 2007b). These employers would need to change the health benefits offered to workers in order to bring the premium down below the cap. Presumably, insurers would respond to the cap by offering a greater choice of lower-priced insurance options to small employers, but what incentive would employers have to offer these plans? *Employers* would not pay extra taxes when they offer health insurance with premiums above the cap—their *workers* would pay the tax. In fact, employers might pay higher taxes when offering lower-cost health plans if the lower-cost health plan corresponded with higher wages, as would be suggested by economic theory. From a tax perspective, employer payroll tax payments would increase were wages to increase because of lower health insurance premiums.

Insurers may respond by offering and marketing lower-cost health plans with premiums below or at the tax cap. Insurers may "shadow price" these plans by offering lower-cost options with a premium at the cap instead of below it. The premiums for lower-cost plans could be artificially high if insurers price these plans at the tax cap, which would defeat the point of a tax cap and affect affordability of health insurance coverage in the nongroup market. And while insurers may start to offer lower-cost plans, employers that are experience-rated and have a less-healthy-than-average work force might be required to pay premiums above the cap.

While large employers are more likely to offer a choice of health plan, when a choice is offered it is usually between two or three plans. Even among employers with 200 or more workers, only 43 percent offered a choice of two or more health plans in 2006, although 65 percent of workers in those firms worked for an employer that offered a choice of health plan.[15]

Payroll Taxes

As mentioned above, under the Bush tax cap proposal, employers that increase wages as a result of reducing the cost of health benefits (as economic theory would suggest) would pay higher payroll taxes. There is also a concern over whether employers would pay higher payroll taxes as a result of the way the tax cap is structured. Employers would be required to add the value of health benefits into workers' taxable income, which means that employers would be required to pay payroll taxes on the imputed income associated with health benefits (although it appears that employer payroll tax payments would then be reduced by the amount of the deduction). The amount to be deducted is complicated by a number of scenarios in which FICA taxes could be under-withheld or over-withheld, as outlined in a recent report.[16]

The proposed standard deduction for health insurance would also affect payroll taxes. In other words, the first $7,500 in income for individuals would not be subject to payroll taxes. Workers could ask their employers to adjust withholding or could wait until they filed their tax return to reconcile any payroll tax

savings. While future Medicare benefits would be unaffected by the reduction in payroll tax contributions, future Social Security benefits would be reduced in proportion to the reduction in Social Security payroll taxes—and workers might not realize that they are trading a tax break today for lower Social Security benefits in the future. In fact, this comes at a time when many workers already are counting on retirement benefits that will not be there, and in the face of already existing ignorance about Social Security benefits, with only a small fraction of workers aware of the age at which they can receive full retirement benefits from Social Security (Helman, VanDerhei, and Copeland, 2007).

Impact on the Uninsured

One of the stated goals of fundamental tax reform as it relates to health insurance is to bring the cost of insurance down so that coverage is more affordable and more people have insurance protection and access to health care services. In 2006, 46.5 million individuals under age 65 were uninsured (Figure 1).

Estimates vary as to the impact of the tax cap proposal on the number of people who would gain or lose health insurance coverage. The Bush administration has estimated that the number of uninsured would fall by between 3 million and 5 million, but also notes that these estimates do not account for the impact of state health reform initiatives on the uninsured. Sheils and Haught (2007) predict that, under the tax cap, the number of uninsured would be 9.2 million lower in 2009 than otherwise projected, after a gain in coverage of 11.5 million and a loss in coverage of 2.3 million. They also estimate that higher-income uninsured individuals would be much more likely to gain coverage under the proposal than low-income uninsured individuals. Specifically, under this estimate, 3.8 percent of the uninsured with income under $10,000 would gain coverage, whereas 38.6 percent of those with income above $100,000 would gain it. Whether the estimate turns out to be 3 million or 9.2 million, a tax cap will not solve the problem of the uninsured: More than 40 million individuals would continue to be uninsured.

Out-of-Pocket Expenses and "Leveling the Playing Field"

It can be argued that low cost sharing or the ability to pay for cost sharing with pre-tax dollars leads to overuse of health care services, which drives up insurance premiums and makes insurance less affordable, especially for lower-income workers. If true, capping the exclusion from income would mean that employers would start to offer (or workers would start to buy) health benefit packages below the caps in order to avoid paying taxes on excess health benefits. Hence, the purpose of eliminating contributions to FSAs is to level the playing field with respect to taxes regarding spending on health care services and spending on other goods and services. Economists have argued that the current tax exclusion for out-of-pocket spending through an FSA gives workers an incentive to spend money on health care services at the expense of other goods and services. While the Bush administration proposal would eliminate contributions to FSAs, it would not eliminate contributions to HSAs.

There are a number of issues with continuing to allow contributions to HSAs on a pre-tax basis. Allowing pre-tax contributions to an HSA tilts the playing field toward high-deductible health plans at the expense of other types of health insurance that may be just as effective at controlling health care use and costs. Allowing pre-tax contributions to an HSA also allows those individuals contributing to an HSA to exceed the proposed standard deduction of $7,500 for individual coverage and $15,000 for family coverage. An individual with an HSA would be allowed to take the $7,500 health insurance deduction and would also be allowed to reduce his or her taxable income by the amount of the contribution to the HSA, which in 2007 was a maximum of $2,850. Hence, an individual making HSA contributions would get a $10,350 deduction from income taxes.

Allowing HSA contributions on a pre-tax basis can create an incentive to overuse health care at the expense of other goods and services. HSA withdrawals are allowed tax-free only for qualified medical expenses. An individual can withdraw funds from an HSA for expenses other than qualified medical expenses if he or she pays income taxes and a penalty tax on the distribution. The penalty is waived for persons age 65 and older, but they would still be required to pay income taxes on any withdrawals at or after age 65. So persons with HSA contributions in the short run would only get value from the savings account by

using it for health care services. These individuals would get a tax break on out-of-pocket spending that other individuals would not receive. And allowing contributions to HSAs would not level the playing field with respect to taxes on health care as compared with spending on other goods and services, as economists suggest should take place to move to a more efficient health care system.

Do Employers Do "Total Compensation"?

The basis for the longstanding argument that employers should be indifferent to whether they pay wages or provide health benefits rests on the labor economic assumption that, in the long run, the worker actually pays for the full cost of health insurance with reduced cash compensation. Were this actually the case, employers could easily cover annual health cost increases with modest reductions in annual salary increases. Were this the case, employers would not do the extensive salary surveys undertaken each year as the guide to salary budgets; they would survey "total compensation" cost, taking into account both pay and benefit expenses.

But the problem is that such total compensation cost data are not generally available. The valuation of pooled group insurance benefits for such a purpose would present widely varied costs as a percentage of pay for a given job class, depending upon the age and health status of each worker. The inclusion of the value of a defined benefit pension plan for such purposes would be equally difficult for a given job and salary class, since years of service would lead to widely different accrual values. In reality, traditional benefits do not actually fit the simplifying assumptions of economic theory at the individual or firm level.

Economists and tax analysts also evaluate the value of the health insurance tax preference as a function of the individual's tax rate, as opposed to the value of the insurance relative to the worker's income. The provision of employer-paid group insurance has its greatest *economic* value—but the lowest *tax* value—to the lowest-paid worker. Family insurance worth $15,000 provided to the employee who makes $20,000 per year and is 55 years old is something he or she would never be able to afford in an individual market that allows any form of age rating. That same insurance worth $15,000 provided to the employee making $200,000 represents a low economic value, but a big tax exclusion value. Yet, that employee could likely afford to purchase the coverage in the individual market, regardless of age or underwriting, whether or not the employer increased his or her salary upon the termination of the provision of health insurance. Such complications are not part of the "simplifying" assumptions necessary for most economic analysis.

Most employers, when asked if they pass on all "savings" from changes in health insurance as cash compensation increases, say no, particularly since they are really simply reducing the amount of increased spending and not realizing a net reduction.

What Should Employers Do?

The debate of taxation of health benefits suggests that employers should revisit why they provide health benefits: Do they provide value? What value? Were large numbers of workers to begin going without insurance or to move to limited coverage in order to garner tax savings, what impact might this have on the employer? If there is a possibility that FSAs and the tax exclusions in cafeteria plans will be eliminated in the future, should employers continue to use them and/or make use of them in new plan designs? What are the communication and other cost implications? As employers begin to face a tightening labor market in the years ahead—as has been projected since 1990, particularly in technical jobs—what role will the provision or nonprovision of health insurance have on the ability to attract and retain skilled employees?

Employers should also consider the implications of new state-based universal coverage programs, such as that enacted in Massachusetts or under consideration in California and more than 20 other states, both in general and in terms of future enactment of the health tax proposals by a later Republican administration.

In addition, employers should also consider whether or not labor economic theory actually applies in the compensation area in the real world, as it is found in the textbooks. Those theories are increasingly driving employee benefits tax policy, but if they are wrong they will lead to significant unintended consequences—not just for workers, but also for employers. In many cases, the consequences could lead to outcomes that are quite different from those desired by health economist advocates of fundamental health tax reform. For all its problems, gaps, and costs, the current employment-based health insurance system covers the majority of

working Americans and their families today; if that system is dismantled for a theory that proves wrong, health coverage in the United States could become a far greater problem than it is now.

For instance, when an employer moves from a final-pay defined benefit pension plan, does it pass on 100 percent of the cost reduction of the move to a hybrid plan to employees in a cash wage increase or added benefits, as labor economic theory holds? Does each individual bear the full cost of his or her benefits, with none of the cost borne, in the long run, by the owner or shareholder? Can workers know that the full value shown on the annual benefits statement would come to them as added cash compensation were the benefits eliminated? Congress, as the largest single employer in the United States, should think about whether any of this traditional labor economic theory of cash compensation and benefits is true for federal employees—especially since the federal government is facing a wave of retirements of its most senior and experienced workers and will be competing with the private sector for highly skilled or technical talent.

Would Tax Credits Be Effective in Expanding Coverage?

Tax credits have been on the radar scope of policymakers even before President Clinton proposed comprehensive reform to the health insurance system (Fronstin, 1999). Tax credits provide a dollar-for-dollar reduction in the amount of tax that a taxpayer owes; unlike deductions or exemptions, which reduce the amount of income *subject* to a tax, a tax credit reduces the actual amount of tax *owed*.

Unsuccessful tax credit bills have been introduced over the years by both Democrats and Republicans, and in some cases, bills were co-sponsored by both. Cunningham (2002) describes what has become the "joint custody" of tax credits among Democrats and Republicans. Former Sen. Lloyd Bentsen (D-TX) was a principal architect of health insurance tax credits enacted during the first Bush administration in 1991. In 1999, then-House Majority Leader Dick Armey (R-TX) and ranking Ways and Means Democrat Pete Stark (D-CA) jointly endorsed tax credits on the opinion page of the *Washington Post*, but their proposal went nowhere (Armey and Stark, 1999). Also in 1999, Stuart Butler of the conservative Heritage Foundation and David Kendall of the (Democratic) Progressive Policy Institute made a joint proposal, as did Reps. Jim McCrery (R-LA) and Jim McDermott (D-WA) in 2000 (Butler and Kendall, 1999, and Miller, 2002). [17]

President Bush has twice previously proposed tax credits as an alternative to the current tax treatment of health insurance. The administration's Fiscal Year 2003 budget included a proposed tax credit of $3,000 for uninsured families, and in 2006, the administration proposed a tax credit that can be used toward the purchase of insurance in the nongroup market. Only families with income below $25,000 would be eligible for the full credit.[18] 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. But unlike past tax credit proposals from the Bush administration, the 2006 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 was not used to purchase health insurance, the remaining amount of the tax credit could be contributed to an HSA.

Recently, President Bush said that he is open to the idea of a tax credit as an alternative to his proposed standard health insurance deduction, but has otherwise not provided new details other than comments from the National Economic Council regarding a $2,250 tax credit for individual coverage and a $4,500 tax credit for family coverage.[19] All else equal, a tax credit would shift tax savings away from higher-income individuals and families and toward lower-income ones, as compared with a standard deduction. For example, a family with taxable income of $7,500 would realize $3,795 in tax savings from the proposed standard deduction, but would realize tax savings of $4,500 from a tax credit at that level (Figure 7). In contrast, a two-income family with total taxable income of $150,000 would realize tax savings of $6,045 under the proposed standard deduction, as compared with $4,500 in tax savings under a tax credit at that level.

A primary issue under both the standard deduction and the tax credit proposals is whether the tax savings are large enough to induce the uninsured to buy health insurance. As mentioned above, with health insurance premiums for families in the $12,000 range in 2007, with the expectation that premiums reach close to $15,000 in 2009, tax savings of $3,795 or $4,500 will not be large enough for many families to afford health insurance. Hence, it should come as no surprise that the number of uninsured would remain at or above 40 million even if (as mentioned above) the estimated net 3 million to 9.2 million individuals were to actually gain health insurance coverage because of changes in the way health insurance is taxed.

Figure 7

Comparison of Tax Savings from Standard Deduction and Tax Credit, by Taxable Income

Individual Taxable Income	Tax Bracket	Standard Deduction: Federal Income Tax Savings	Standard Deduction: FICA Savings	Standard Deduction: Total	Individual Tax Credit
$0	0%	$0	$1,148	$1,148	$2,250
$7,500	10	750	1,148	1,898	2,250
$25,000	15	1,125	1,148	2,273	2,250
$50,000	25	1,875	1,148	3,023	2,250
$150,000	28	2,100	218	2,318	2,250
$250,000	33	2,475	218	2,693	2,250
$500,000	35	2,625	218	2,843	2,250

Family Taxable Income	Tax Bracket	Standard Deduction: Federal Income Tax Savings	Standard Deduction: FICA Savings	Standard Deduction: Total	Family Tax Credit
$0	0%	$0	$2,295	$2,295	$4,500
$7,500	10	1,500	2,295	3,795	4,500
$60,000	15	2,250	2,295	4,545	4,500
$100,000	25	3,750	2,295	6,045	4,500
$150,000	28	4,200	2,295	6,495	4,500
$250,000	33	4,950	435	5,385	4,500
$500,000	35	5,250	435	5,685	4,500

Source: Employee Benefit Research Institute.

The ability of a tax credit to reduce the uninsured population depends heavily on several key design issues, such as the size of the tax credit relative to income and income levels overall. Previous research has shown that for single workers with income at 150 percent of the federal poverty level (FPL), only 48 percent would gain coverage even if the tax credit was set to 79 percent of the premium (Thorpe, 1999). In addition, a tax credit equal to the full amount of the premium would result in 75 percent of the population of single workers at 150 percent of FPL receiving coverage.

The findings of Thorpe (1999) are reinforced by experiments undertaken by The Robert Wood Johnson Foundation's Health Care for the Uninsured Program in the late 1980s that were able to reduce premiums for the self-employed and workers in small firms. Despite premium reductions ranging from 9 percent to 60 percent, with most in the 25 percent and 50 percent range, no single site in the experiment reached 10 percent of its target market (Helms, Gauthier, and Campion, 1992). Hence, even very generous tax credits may not be large enough for a significant portion of the low-income population to purchase health insurance. Based on the work of Thorpe (1999), with today's premiums, a tax credit of about $12,000 for families with income at 150 percent of the federal poverty level could leave 25 percent of those families uninsured.

Conclusion

Politically, President Bush's latest health tax proposals were effectively dead even before arrival on Capitol Hill. Yet, they are largely consistent with past recommendations of groups ranging from the Committee for Economic Development, to multiple current members of the Congress, to 2008 presidential candidates.

At least two major issues are driving this debate. The first is a longstanding debate over whether employers should be encouraged to provide health insurance with special tax provisions, or whether the emphasis should be on an individual market and individual choice. The intensity of this debate has increased in each of the last four decades and shows no signs of going away. Second, as pressure grows to finally deal with long-term deficits and the pending insolvency of Social Security, Medicare, and Medicaid, fundamental tax reform is likely to find its way onto the national agenda.

Given the size of the current amount of foregone revenue attributed to employment-based health and retirement benefits, employee benefit tax incentives will undoubtedly be on the table as well. Since many of

the proposals to change health tax treatment include expanding tax preferences for individuals, long-term fiscal issues could affect the structure of all health tax proposals. This *Issue Brief* attempts to underline the complex mix of issues that should be considered when the debate ensues: However the system is changed, the nation's health may rest in the balance.

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Endnotes

[1] See http://www.joinrudy2008.com/commitment.php?num=7

[2] Employers do not get a tax break on Social Security taxes for workers whose incomes are above the wage base because they already do not pay Social Security taxes on the amount of income above the wage base for these workers.

[3] These limits are indexed to inflation. In 2008, the minimum deductible of $1,100 for individual coverage and $2,200 for family coverage will remain unchanged, but the maximum out-of-pocket limit will increase to $5,800 for individual coverage, and $11,200 for family coverage.

[4] The maximum contribution levels will increase to $2,900 for individual coverage and $5,800 for family coverage in 2008.

[5] Catch-up contributions are not indexed to inflation.

[6] See http://www.house.gov/jct/x-17-07.pdf

[7] See Exhibit 4.2 in http://www.kff.org/insurance/7527/upload/7527.pdf

[8] It can not be determined whether these individuals are covered by a retiree health benefits or by COBRA.

[9] See Exhibit 1 in http://www.kff.org/insurance/snapshot/chcm020707oth.cfm

[10] See Exhibit 6.3 in http://www.kff.org/insurance/7527/upload/7527.pdf

[11] It should be noted that these workers may not leave the employment-based system entirely; they may choose to be covered by a spouse's employer and demand payment from their own employer. But, what does the employer pay them when the employer knows, especially the self-insured employer, that the actual cost of the insurance they are being provided is well below the average premium in the plan? (It should be noted that some proposals now before Congress introduced by Democratic and Republican lawmakers would require that employers make these payments to workers.)

[12] See http://www.cch.com/press/news/2006/20061206h.asp

[13] See http://www.taxpolicycenter.org/TaxModel/tmdb/TMTemplate.cfm?Docid=1445&DocTypeID=1

[14] See www.ibiweb.org/publications/download/637

[15] See Exhibit 4.2 in http://www.kff.org/insurance/7527/upload/7527.pdf Note that not all 57 percent of workers employed by a firm offering a choice of health plan were in fact offered a choice.

[16] See http://www.house.gov/jct/x-17-07.pdf

[17] Other examples of tax credit proposals can be found in Fronstin (1999) and Cunningham (2002).

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

[19] See http://www.whitehouse.gov/news/releases/2007/06/20070627-10.html and http://www.whitehouse.gov/news/releases/2007/06/20070627-16.html

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