No. 728

ISSUE BRIEF

NATIONAL HEALTH POLICY FORUM

Retooling Tax Subsidies for Health Coverage: Old Ideas, New Politics

Thursday, November 12, 1998
Washington, DC

With presentations by

Bob Lyke
Specialist in Social Legislation
Congressional Research Service

C. Eugene Steuerle
Senior Fellow
Urban Institute

Mark V. Pauly
Chair and Professor of the Health Care Systems Department
Wharton School
University of Pennsylvania

and comments from

Harry J. Conaway
Head of the Washington Resource Group
William M. Mercer, Incorporated

John K. Meagher
Senior Special Counsel
Committee on Ways and Means
U.S. House of Representatives

Sonia Conly
Financial Economist
U.S. Department of the Treasury

James S. Ray
Partner
Connerton & Ray

The George Washington University
WASHINGTON DC

Retooling Tax Subsidies for Health Coverage

Over the past year, renewed interest has emerged, both on Capitol Hill and among market-oriented think tanks, in making major reforms to the health care system by altering the federal tax code. The push for change appears to be coming from two quarters. Recently, many economists and health policy analysts who have long argued that the current tax system is unfair on several counts and creates incentives for inefficiency have joined forces to make the case for reform. Meanwhile, some members of Congress have renewed discussions about reforming the taxation of the health system. Some Republicans have gone as far as coupling the idea of tax reform with an individual mandate to purchase insurance in an effort to ensure that all Americans have access to care while maintaining competitive markets for health insurance and health services.

Changing the federal tax system can mean many things, even among people who think they are in agreement when promoting a broad idea whose details have yet to be ironed out. With this caveat in mind, there appear to be at least three thrusts to these tax proposals:

- Improving economic efficiency in the health system by limiting the currently open-ended tax exclusion of health benefits provided by employers and unions.
- Retargeting tax subsidies from higher earners to lower earners.
- Removing the tax code's bias toward employment-based coverage and creating an at least equal tax incentive for the purchase of individual coverage.[1]

Each one of these policy goals raises many technical issues as well as political resistance. It is particularly unclear from discussions to date what role would be ascribed to employers and unions, which now sponsor health coverage for most Americans, in a reformed system in which tax subsidies might be tailored to individuals. It is also unclear how the proposed changes in tax policy relating to health care might comport with discussions of broader tax reforms, such as shifting to a consumption tax or flat tax.

This Forum session will examine the current tax treatment of health coverage and health care spending and explore the potential impact of proposed tax reforms. Special attention will be paid to what role employers and unions play in organizing coverage, how that role might be maintained if the tax system were altered to make the system more efficient and equitable, and what elements of the health care system might have to be recreated if employment-based coverage declined in favor of individual-based coverage.

CURRENT TAX TREATMENT

Federal tax law stimulates the consumption of health care and health insurance over other goods and services in several ways. Furthermore, within the health care sphere, it favors health coverage paid for through employers and unions over that paid for by individuals.

The most significant feature of the federal tax treatment of health care is that health coverage provided through employment is excluded from an employee's gross income in determining his or her tax liability.[2] It is also not considered for either the employee's or employer's share of employment taxes (Social Security, Medicare, and unemployment taxes) and may be deducted as a business expense by the employer.

While employment-based group coverage is excluded from taxation, tax breaks for individually purchased health insurance are far narrower. Taxpayers who itemize their deductions may deduct unreimbursed medical expenses, including insurance premiums, to the

ISSUE BRIEF/No. 728

Analyst/Writer
Karl Polzer

National Health Policy Forum
2021 K Street, NW, Suite 800
Washington, DC 20052
202/872-1390
202/862-9837 (fax)
nhpf@gwu.edu (e-mail)
www.nhpf.org (Web site)

Judith Miller Jones, Director
Karen Matherlee, Co-Director
Sandra M. Foote, Co-Director
Michele Black, Publications Director

NHPF is a nonpartisan education and information exchange for federal health policymakers.

extent that they exceed 7.5 percent of adjusted gross income,[3] but only about 4 percent of all tax returns claimed this deduction in 1996. The Congressional Research Service points out that this tax deduction is little utilized because, for most taxpayers, the standard deduction is larger than the sum of itemized deductions. Also, most people's unreimbursed medical expenses do not exceed 7.5 percent of adjusted gross income.

The tax system's bias toward employment-based health coverage is reflected by the difference in federal "tax expenditures"[4] between the tax exclusion for group benefits and the deduction for individual expenses. The Joint Committee on Taxation (JCT) estimates that, in fiscal year (FY) 1998, federal tax expenditures due to the exclusion from income tax of employer contributions for health insurance, medical care (including that provided through cafeteria plans and flexible spending accounts), and long-term care insurance amounted to $51.4 billion. In contrast, the JCT estimates the tax expenditures due to the medical expense deduction, including long-term care expenses, to be $4.4 billion.

The Department of Treasury estimates federal tax expenditures due to the exclusion of employer contributions for medical insurance premiums and medical care to be $71.5 billion in FY 1998. Tax expenditure estimates produced by the two branches of government differ for many reasons, including different conceptual assumptions and different methods of accounting. For example, in estimating tax expenditures due to the exclusion of employer-provided health coverage, the JCT assumes that more deductions would be made under the individual medical expenses category in the absence of the exclusion, while the Department of the Treasury does not, according to a treasury staff economist. In addition, the Treasury Department lumps together the tax-exclusion of employer-provided coverage and the self-employed deduction, described below, when it reports its estimates of tax expenditures, while the JCT reports tax expenditures for the self-employed deduction as a separate item. Neither the administration nor the JCT incorporates employment taxes (such as those used to fund Social Security and Medicare) in calculating tax expenditure estimates.

The Lewin Group estimates that "total federal tax expenditures" for employer-provided health benefits came to $96.1 billion in 1996. Of that total, $60.3 billion (62.7 percent) was related to income tax, $24.5 billion (25.5 percent) was related to Social Security taxes, $6.9 billion (7.2 percent) to Medicare taxes, and $4.4 billion (4.6 percent) to out-of-pocket deductions. Lewin estimates that state tax expenditures for employer health benefits in 1996 came to an additional $12.4 billion.

According to the Treasury Department, exclusion of employer contributions for medical insurance premiums and medical care generates more federal tax expenditures than any other tax break related to the income tax: $76.2 billion in FY 1999, compared to $72.4 billion for the exclusion of employer pension plan contributions and earnings and $53.7 billion for the deductibility of mortgage interest in owner-occupied homes.[5]

The Internal Revenue Service (IRS) has treated employers' contributions toward employees' accident and health insurance as nontaxable fringe benefits since the income tax was first levied in 1913.[6] Until 1943, the IRS made no specific ruling about employer contributions for health plans, but rather took the general position that most fringe benefits not paid in cash should be excluded from taxation. When the government imposed wage and price controls during World War II, more firms began offering fringe benefits to compete for workers.[7] After the War Labor Board ruled that health and pension benefits did not count as wages, the IRS declared that employer-provided health insurance was excludable from taxable income in 1943. (The medical expense deduction dates back to 1942.) As the economy grew rapidly in the post-war years, many more firms began offering health benefits. Increases in tax rates after World War II provided added incentive to offer tax-excluded fringe benefits.

Under the current tax code, self-employed taxpayers may deduct payments for health insurance in determining their adjusted gross income. In contrast to the medical expense deduction, the self-employed deduction is not restricted to itemizers. The deduction is limited to 45 percent of the amount paid for insurance in 1998 and 1999, with the limits increasing as follows: to 50 percent in 2000 and 2001, 60 percent in 2002, 80 percent in 2003 through 2005, 90 percent in 2006, and 100 percent in 2007 and thereafter. The self-employment deduction is not available for any month in which the taxpayer or taxpayer's spouse is eligible to participate in an employment-based health plan for which the employer pays part of the cost. The JCT estimates the tax expenditure in FY 1998 for this deduction to be only $0.8 billion.

Health benefits provided through cafeteria plans and flexible spending accounts are excludable from both income and employment taxes. Federal law also allows a limited number of medical savings accounts (MSAs)

to be established by taxpayers who are either self-employed or work for a small employer. Employer contributions to MSAs are excludable from both income and employment taxes, while individuals' contributions are deductible for determining adjusted gross income.

CRITICISMS OF CURRENT SYSTEM

Many analysts have criticized the tax exclusion of employer-provided health coverage, especially on grounds that it is creates market distortions and inefficiencies and is unfair in that it favors people in certain work situations and those in higher income groups. Economist Mark Pauly, for example, recently wrote that the tax exclusion is "mistargeted" (being available only through group coverage), "miscalibrated" (by offering stronger incentives to be insured to persons in higher tax brackets), and "open-ended" (encouraging the consumption of health insurance at levels exceeding a socially adequate amount).[8]

Costs

Subsidizing the purchase of health insurance through the tax system at any point in time will lower the cost of coverage and increase the ability of individuals to obtain it. In the long run, however, the effect of such a subsidy, particularly if it is open-ended, may be to increase health costs and, thereby, deny health coverage to many who no longer may be able to afford it. This long-term phenomenon may occur because, when health benefits are favored by the tax code over cash wages, employers and employees negotiating over compensation face an incentive to increase health benefits as opposed to wages; each dollar of untaxed health benefits purchases a dollar's worth of health coverage, while each dollar of wages is reduced by the tax rate. Over time, such an incentive structure, if open-ended, will favor the growth of health insurance as opposed to cash wages as well as the inclusion of more items in insurance packages. Greater amounts of health insurance, in turn, can lead to greater utilization of medical services and upward pressure on prices and expenditures. In theory this occurs because once insurance premiums are paid (or group coverage is established), individuals consuming goods and services do not pay the incremental cost of those services at the point of utilization, thereby removing the incentive to shop as prudently as they would for other types of services. In addition, the fact that a third party is paying may increase providers' ability to raise price levels.

For these reasons, the short- and long-term effects of a tax system that favors health insurance may be divergent. One way to mitigate the long-term cost effect would be to limit the tax exclusion to a fixed amount. However, in the short run, reducing the amount of tax subsidy might increase the cost of health coverage for employees, thereby causing more to be uninsured.

Most of the cost of health care is paid for through third-party insurance programs. Eugene Steuerle and Gordon Mermin estimate that in 1996 only about one-quarter of Americans' health care spending was paid for out of pocket. By their account, the nation spent about $11,000 per household on health care that year. About half this spending was financed indirectly through higher federal, state, and local taxes to support government programs and to compensate for revenue lost due to the tax treatment of health care. About $2,000 of the total was paid indirectly through lost wages for employer-provided health benefits.

There is some empirical evidence to back up the theoretical arguments that third-party payment causes costs to rise. The RAND Health Insurance Experiment, for example, demonstrated that increasing the level of cost sharing in insurance plans decreased utilization of services. Circumstantial evidence of the inflationary tendencies associated with health insurance can be found by examining long-term cost trends since 1970. (By that time, employer-provided health insurance had become conventional and the government had established the major federal health entitlement programs, Medicare and Medicaid.) Since 1970, national per capita health expenditures have always grown faster than the underlying rate of inflation, though at a slower rate in recent years. Real per capita growth in national health expenditures averaged 4.5 percent from 1970 to 1980, 5.1 percent from 1980 to 1990, and 4.2 percent from 1990 to 1993, but dropped to 1.5 percent in 1993 to 1996 and 2.6 percent in 1996 to 1998.[9] According to the Health Care Financing Administration (HCFA), Office of the Actuary, it is conventional wisdom that the slowdown in real growth rates has been due to the increased use of managed care strategies by many purchasers, particularly in the private sector. Nonetheless, questions remain about whether the shift to managed care can permanently reduce the growth rate. HCFA projects that the real annual per capita growth in national health expenditures will rise to 3.1 percent from 1998 to 2001 and to 3.4 percent from 2001 to 2007.

As costs have gone up, so have the number of Americans without health insurance. The U.S. Census

Bureau recently reported that there were 43.4 million uninsured Americans in 1997, about 1.7 million more than in 1996.[10] About 16 percent of the population is now uninsured, up from about 11 percent in 1980.[11] Eighty-four percent of the uninsured are in families in which at least one person is working, according to the Employee Benefit Research Institute.

Equity

The current tax treatment of health care can be viewed as unfair in many ways. The tax exclusion is available to people offered health benefits by their employers or unions, but not to those who work for firms where such group coverage is not offered.[12] Furthermore, the exclusion favors higher-income workers. For one thing, higher-income families are more likely to receive health benefits from their employers. Eighty-seven percent of individuals with family income greater than 400 percent of poverty receive employer-based insurance, while only 48 percent of those between 100 percent and 200 percent of poverty do. Also, higher-income families are more likely to have more generous coverage and they face higher tax rates, both of which increase the value of the exclusion. According to estimates done by the Lewin Group, federal tax breaks for health care were worth an average of $918 per family in 1996. The subsidies amounted to only about $63 per family for those earning less than $15,000 and $288 for those earning $15,000 to $19,999, while they were worth $1,767 for families earning $75,000 to $99,999 and $2,059 for families earning $100,000 or more.

Market Distortions

Another set of criticisms of the tax treatment of health care is that it creates market distortions that leave many Americans less satisfied than they otherwise would be with their health plans. One distortion already referenced is that the tax system favors the growth of third-party payment, thereby increasing resources dedicated to health care and reducing what society may spend on other things. Another distortion, some economists argue, is that it is biased toward having people receive benefits through their employers, who, in turn, may limit their choices or simply not offer health benefits at all.

An important questions in this context is what policies might replace the tax exclusion of employer-provided health coverage if it were limited or eliminated and what market distortions such alternative policies might entail. While the employment-based tax subsidy system certainly is flawed, employers and other group plan sponsors currently provide essential functions in the marketplace. These functions include the pooling of risk, the administration of health plans (including easy withholding of funds for premiums), and, in some cases, the ability to negotiate with health insurers, third-party administrators, and the providers of medical services for better value. What institutions might perform these functions if employers stopped providing them is an open question.

One Treasury Department economist described the tax exclusion of employer-provided coverage as "the glue that holds the employer-based system together." This tax incentive is an important factor in leading employers to offer coverage and employees to form risk pools. It is difficult to predict how employers might respond to a change in the tax treatment of health benefits. If the tax incentive were reduced, many employers might still offer health benefits to attract the best available workers or simply because people generally expect them to provide health coverage, but many might stop doing so.

Today, nearly two-thirds of the noninstitutionalized population under age 65 receives employment-based coverage. On average, large employers pay about 80 percent of its cost. Also, about 34 percent of people 65 and older had employer-based coverage in 1996, primarily as a supplement to Medicare.[13] In the private sector, about 125 million people are covered through about 2.5 million health plans organized by employers and unions under the federal Employee Retirement Income Security Act of 1974 (ERISA). In the public sector, about 10 million federal employees, dependents, and annuitants receive coverage under the Federal Employees Health Benefits program, and roughly 20 million receive group health coverage from state and local governments.

Under ERISA, private-sector employers or employee groups (unions) may offer "welfare benefit plans," including health plans. While ERISA provides plan participants with certain protections,[14] the law grants employers considerable flexibility with which to organize and finance health plans. In keeping with the voluntary nature of private-sector health coverage, ERISA allows sponsors to terminate a health plan at any time. In recent years, the adequacy of ERISA's consumer protections has come under question and has led to fierce debate in the Congress about how to bolster them, perhaps in part because many employers have shifted to managed care plans, leaving employees with less choice of providers and more barriers to receiving services.[15] The difficulty in resolving these

issues may well be another factor that has brought some members of Congress to consider alternatives to the employer-based system. For example, some employer representatives have testified that employers will stop offering coverage if plan participants' court remedies are expanded. In general, employers argue that "over-regulation" of health benefits will increase costs, thereby reducing their ability to offer coverage.

In a recent book, Pauly points out that subsidizing employer-paid health benefits through taxes "can lead to excessive employer interference in the choice of the form and amount of health benefits."[16] He goes on to posit:

> With employees ignorant of the full cost of the benefit they receive, their reactions appear to run to two polar cases—either they ignore the details of their "free" insurance[17] or they discover to their alleged surprise that the benefits are not as good as they thought. This pattern, one may speculate, led many employers to move aggressively into managed care and then caused many employees to react in horror at finding that this coverage was, in some dimensions, not as permissive or accommodating as the more costly conventional insurance coverage they were used to receiving.

While conditioning tax incentives on employment creates distortions that may frustrate some employees, it is important to note that the federal tax code provides employers with ways to offer employees considerable choice of nontaxable benefits, including health coverage. Section 125 of the Internal Revenue Code, created by the Revenue Act of 1978, introduced several types of tax-qualified flexible benefit plans, including those offering employees a choice between at least one qualified nontaxable benefit and one taxable benefit including cash.[18] Section 125 allows premium conversion plans (which allow employees to pay for group health premiums through pretax salary reduction), flexible spending accounts (which allow employees to set money aside for qualified unreimbursed medical or dependent care expenses through pretax salary reduction), and cafeteria plans (which must offer a combination of qualified nontaxable benefits and taxable benefits or cash). Often established to respond to individual employee needs, these plans are more prevalent among larger employers. In 1995, for example, 54 percent of full-time employees surveyed in medium and large private establishments were eligible for cafeteria plans and/or flexible spending accounts.[19] In 1994, 19 percent of full-time employees in small private establishments surveyed were eligible for cafeteria plans and/or flexible spending accounts.

If judged by whether people have access to health coverage, the employment-based system produces mixed results. People working in small firms, for example, are much less likely to be offered health coverage than those working for large firms. In 1996, only 48 percent of firms with fewer than 50 employees offered health insurance, compared to 91 percent of firms with 50 to 99 workers and 99 percent of those with 200 or more workers.[20]

Employers with predominantly low-wage employees also are less likely to offer health coverage to their workers than employers with higher-wage workers (but the difference tends to diminish as firm size increases), the General Accounting Office (GAO) reports. Among firms with up to 50 employees, for example, only 19 percent of those where most workers earned less than $10,000 offered health benefits, compared to 51 percent of those where most workers earned at least $10,000 (a difference of 32 percentage points). Among firms with more than 200 employees, 87 percent of those where most workers earned less than $10,000 offered health benefits, compared to 97 percent of those where most workers earned at least $10,000 (a difference of 10 percentage points).

It is difficult to determine to what degree firms that offer health benefits structure their contributions to "subsidize" premiums for particular groups of employees—for example, shifting costs from low-wage workers to those earning more (or vice versa), from younger employees to older, or from single employees to those with families. However, it is reasonable to assume that firms now internally distribute the cost of health premiums in a wide variety of ways, thereby compounding the difficulty that health and tax policy analysts face in projecting the impact on households of curtailing subsidies for employer-provided coverage and moving toward a tax system based on individual purchase of coverage.

Larger firms' advantage in offering health coverage and possibly in subsidizing it for low-wage workers may result for several reasons. The larger the pool of workers covered in an employer plan, the less variability there is in health care costs and the less need there is to purchase insurance. The larger the pool, the lower the costs of administering the plan and the greater the bargaining leverage with service providers. The Hay/Huggins Company, Inc., estimated that in 1988 average administrative and other overhead costs exceeded 35 percent of premium for firms with fewer than 10 employees, compared to 12 percent or less for firms with more than 500 employees.[21] These added administrative costs may put some small firms at a disadvantage with large firms in competing for workers.

ALTERNATIVES

As noted above, support for major reform of the tax treatment of health care appears to be growing in two quarters: among some academicians attempting to influence public policy and among some lawmakers. In July, a group of policy analysts and economists, organized under the rubric of "The Consensus Group," advanced a set of guidelines for replacing the tax exclusion of employer-provided health benefits. According to these guidelines, assistance for purchasing health coverage:

- Should be limited to a fixed amount and not be open-ended.
- Should be provided directly to individuals (who in turn could buy either individually or through groups).
- Could include tax credits or alternate financial incentives adjusted to reflect risk or financial need.
- Should not result in an increase in the tax burden for the American people and could reduce taxes, particularly in the context of major tax reform.

Signatories of the Consensus Group's "A Vision for Reform: Consumer-Driven Health Care Reform," dated July 1998, include Grace-Marie Arnett of the Galen Group, Bradley Belt of the Center for Strategic and International Studies, Stephen Entin of the Institute for Research on the Economics of Taxation, Robert Helms of the American Enterprise Institute, John Goodman of the National Center for Policy Analysis, David Kendall of the Progressive Policy Institute, Robert Moffit of the Heritage Foundation, Pauly of the University of Pennsylvania's Wharton School, Steuerle of the Urban Institute, and Michael Tanner of the Cato Institute, as well as others.[22]

Limiting the value of the existing tax exclusion of employer-provided health benefits can be accomplished in several ways, including imposing a flat tax rate on the total amount of employer payments for health care, according to Steuerle and Mermin. Another way is to cap the exclusion, a strategy that in some cases could require the calculation of health insurance costs for each employee. A tax cap could be designed, however, so that companies contributing less than some "bright-line" amount might avoid having to make such calculations.

Tax incentives directed at individuals could come in the form of an expanded deduction or a tax credit.[23] Expanding the current deduction has many limitations. This approach would still favor those in higher tax brackets and would give no help to those who earn too little to have a tax liability.

Refundable tax credits in many ways resemble direct subsidies for health insurance premiums such as those proposed under the Clinton health reform plan and many health reform bills during the 103rd Congress. With a refundable credit, if the amount of allowable credit exceeds a person's tax liability, the difference is payable to the individual. Many tax credit proposals would provide subsidies to cover the entire cost of health coverage for the poorest families, with subsidies diminishing as income increases. As with any income-related subsidy, one issue that arises with refundable tax credits is that they may create a disincentive to work for some people as increased earnings lead to a reduction in subsidy.[24] Moreover, if tax credits covered only part of the cost of a health plan, in a voluntary system many people receiving credits would choose not to buy health insurance. There is also the question of how well the tax credit might keep pace with medical inflation.

A system of tax credits to buy health insurance also presents administrative difficulties. For one thing, at least at the beginning of such a regime, individuals would receive the credits to purchase coverage only when they filed tax returns during the year *after* they had consumed the insurance, while health insurers typically require premiums to be paid *in advance*. As Steuerle suggests, however, employers could reflect the credit in withholding if the subsidy were simple to calculate (for example, if it were not income-conditioned). Another way to overcome the timing problem would be for the government to provide individuals with vouchers, instead of tax credits, with which to purchase health insurance.

CBO Simulations

In 1994, the Congressional Budget Office (CBO) evaluated three illustrative options for changing tax subsidies for employment-based health coverage: (*a*) capping the tax exclusion, (*b*) eliminating the exclusion altogether, and (*c*) replacing it with a refundable tax credit.[25] In general, the CBO noted that all three options would offer potential gains in efficiency and all three would generate additional costs related to administration and compliance. The overall distributive effects of any of the proposals would depend on how the tax revenues gained from the reforms would be spent. (For example, revenue gains could be spent to reduce government debt, to build roads, to subsidize health coverage for the poor, or for other purposes.)

Capping the exclusion. In simulating effects of a cap, the CBO assumed that the amount of health insurance premiums that could be excluded from taxable income

would be $4,000 for joint returns, $3,400 for heads of households, and $1,600 for single returns—levels that corresponded roughly to what employers typically contributed toward health coverage for different size families in 1994. The CBO estimated that caps at these levels would raise tax revenues by about $18.9 billion in 1994 ($12.4 billion in income taxes and $6.4 billion in Social Security payroll taxes). Caps such as these generally would increase average tax liability as incomes rose, ranging from virtually no change for the lowest-income group up to a $540 tax increase for those earning between $100,000 and $200,000.

Eliminating the exclusion. The CBO estimated that repealing the tax exclusion would raise about $44 billion in income tax revenues and $30 billion in Social Security payroll taxes in 1994, but that doing so would fundamentally change the health system. *In the absence of providing an alternative subsidy*, removing the tax exclusion could cause a dramatic drop in the number of people with health insurance. For example, the CBO estimated that the number of people covered by health insurance could fall by 16 percent to 26 percent if the average price of insurance increased by 35 percent.

Establishing a tax credit. The CBO's illustrative tax credit option was designed to replace the tax exclusion on a revenue-neutral basis in 1994. For very low-income families, the credit would equal 100 percent of premiums up to $1,775 for single returns, $4,425 for joint returns, and $3,750 for head-of-household returns, and it would be phased out for those with incomes between one and three times the lowest income level. A family with an adjusted gross income of $25,000 in 1994, for example, would qualify for a 72.6 percent tax credit on premiums up to $4,425. The CBO concluded that the illustrative tax credit would expand insurance coverage by providing 100 percent subsidies for the poor while giving people with moderate incomes an incentive to seek less expensive insurance. The average family earning less than $10,000 in 1994 would have a net reduction in taxes of $740, while people in the highest-income categories would pay more taxes and receive virtually no benefit from the illustrative tax credit. As with any tax preference that is phased out as income rises, the tax credits might cause people to work less and might discourage spouses from entering the labor market.

INTEREST ON THE HILL

During the debate over national health care reform early in President Clinton's first term, many tax-reform bills were introduced, including measures that would cap the tax exclusion, eliminate it, or replace it with a tax credit. After the demise of the Clinton health initiative, interest in tax reform waned, with some exceptions. Some members of Congress from both sides of the aisle have recently shown renewed interest in reforming the taxation of health coverage.

On the Democratic side, for example, Rep. Jim McDermott (D-Wash.) has proposed providing tax filers lacking employer-based health insurance with tax credits of up to 30 percent of the cost of individually purchased health insurance (H.R. 539). Almost 40 million non-elderly Americans who were either uninsured or bought individual policies during 1996 would have been eligible for the proposed tax credit in that year, according to the GAO.[26]

In recent months, some Republican members of the House of Representatives have publicly broached the idea, at least in general terms, of coupling tax reforms with an individual mandate to purchase health insurance. In a September 9 speech at the Cato Institute, for example, Rep. Bill Thomas (R-Calif.), chairman of the health subcommittee of the House Committee on Ways and Means, made such an overture after calling the current combination of tax-favored, employment-based coverage and various government programs "a rigged game" that invariably works to the political advantage of the Democratic party. Thomas argued that, under its current structure, the health care system is inexorably moving toward more government control as employer coverage erodes due to rising costs and as lawmakers face pressure to expand government programs and market regulation in response. While this type of dynamic has tended to put Republicans on the defensive in one set of incremental reform discussions after another, Thomas argued that the party instead should attempt to take the high ground and try to reshape the health system in a way that minimizes the amount of government interference in the provision of health insurance and medical care. If Congress were to change tax incentives to move away from employer-provided health benefits, Thomas added that changes would have to be practical and many subsidiary issues would have to be addressed. For example, new structures might be needed to pool risk, provide information about health benefits alternatives, and administer health benefit programs.

Providing insurance through a mandate raises difficult political issues. As evidenced during the debate over universal health insurance five years ago, a mandate to purchase insurance immediately raises the

question of subsidizing those who otherwise would not buy it and arguably cannot afford it. Even if the government did away with the current tax system and reallocated $70 billion in tax breaks among 60 million households not receiving Medicare, Medicaid, or other direct public health benefits, only about $1,150 could be provided per household in subsidy, Steuerle and Mermin point out.[27] More government support might be needed to make a significant dent in the number of uninsured. Steuerle and Mermin go on to say:

> Even with some significant efforts at shifting expenditures and subsidies, however, it is highly unlikely that we would have enough to cover most of the cost of today's more comprehensive insurance policies. This has become the classic dilemma of health reform. The system has become so expensive—in part because of how inefficiently government spends all its health care subsidies—that to raise hundreds of billions more to fill gaps for the non-Medicare and non-Medicaid population would require much higher tax rates and would continue the conversion of the federal government into little other than a provider of health care and pensions.

Barring an infusion of new spending, reallocating tax subsidies to the poor would come at the expense of those with higher incomes, who currently receive the greatest benefits from the tax code and who have more clout with elected officials. As evidenced during the Reagan administration, proposals merely to cap the tax exclusion of employer-provided benefits (much less to eliminate it) might draw strong resistance from employers, unions, insurers, and those health providers who fear that their services might be left out of insurance packages that could shrink in response to smaller subsidies.

Moving the health system away from employers and toward individuals raises the question of who would organize coverage on behalf of individuals. Would sponsorship organizations such as purchasing cooperatives have to be developed to do this? In the absence of a group sponsor, how could individuals negotiate with health insurers and providers? (Market-based think tanks that advocate a system based on individual choice often point to the federal employees program, which offers several health insurance options in every area of the country, as a model. This program, however, is the largest employer-sponsored plan in the country.) If individuals had to fend for themselves in the individual market to purchase a federally mandated insurance package, a key question would be what obligation the federal government might have to regulate health insurance (a market now under state authority) to ensure that adequate policies were available, plan solvency were maintained, and consumers protected from abuse.

Steuerle and Mermin propose a tax reform strategy that would maintain a role for employers in administering health benefits, while it would (*a*) cut back the value of the existing exclusion, (*b*) provide a tax credit to individuals to buy health insurance, and (*c*) penalize individuals with moderate or higher incomes who do not purchase insurance.[28] Noting that some employers might be tempted not to sponsor health plans if tax subsidies for group coverage were simply cut back, they suggest that employers should be required *to offer* health plans upon which tax credits might be spent, though not necessarily required to contribute toward the plans' cost. They also suggest that employers reflect credits and penalties in withholding.

Although support for overhauling the taxation of health coverage according to principles described in this paper appears to be building, recent activity in Congress seems to be headed in the opposite direction—that is, extending tax benefits available through employment-based health coverage. Republican-sponsored patient protection legislation (H.R. 4250 and S. 2330), for example, includes measures that would expand the availability of tax-advantaged medical savings accounts, accelerate the health insurance deduction for the self-employed, and allow carryovers and rollovers of unused benefits in cafeteria plans and flexible spending accounts.[29]

THE FORUM SESSION

The session will begin with three short presentations, followed by a roundtable discussion involving several panelists. Bob Lyke of the Congressional Research Service will begin by outlining the current tax treatment of health care and summarizing recent congressional activity. Economists Mark Pauly and Eugene Steuerle then will discuss the rationale for reforming the taxation of health care as well as ideas on how to do it. Both also will address the role employers and unions currently play in organizing coverage for employees and how that role might change if tax subsidies were geared more toward individual purchase of health insurance. The panel will include Harry Conaway of William M. Mercer; Jim Ray of Connerton & Ray; Sonia Conly of the Department of the Treasury; and John Meagher, special counsel, House Committee on Ways and Means.

Issue Questions

Discussion will address the following questions:

- What would be the likely effects, both in the short and long run, of capping or eliminating the exclusion

from taxation of employment-based health coverage? Over time, would such reforms help control the growth of health care expenditures by reducing the incentive to receive compensation in the form of health insurance?

- What would be the effect of replacing the tax exclusion for employment-based health coverage with refundable tax credits for individuals? What are the options for designing such a policy and what major issues arise (for example, political opposition, administrative feasibility, budgetary constraints)?
- What might be the impact in the labor market of refundable tax credits that diminish in value as income rises?
- What are the strengths and the weaknesses of employment-based health coverage? If the tax incentives are changed to encourage individual coverage, what other policy reforms might be necessary? Would other sponsorship organizations have to be developed? Would the federal government face more pressure to regulate the individual insurance market, especially if tax reforms were coupled with an individual mandate?
- How might changing the tax treatment of health care fit into broader tax reform strategies?

Speakers and Discussants

Bob Lyke is a specialist in social legislation at the Congressional Research Service (CRS) of the Library of Congress. He was educated at Swarthmore College, Balliol College (Oxford), and Yale, where he earned a Ph.D. degree in political science. After teaching at Bryn Mawr and Princeton, he began working at CRS in 1975, initially on school finance issues. Currently, his work focuses on tax issues involving education and health care. He is a certified public accountant and has taught tax accounting courses at the University of Maryland since 1993.

Mark V. Pauly, holds the positions of vice dean of the Wharton Doctoral Programs, Bendheim Professor, and chair of the Department of Health Care Systems. He is professor of health care systems, insurance, and risk management and public policy and management at the Wharton School and professor of economics in the School of Arts and Sciences at the University of Pennsylvania. One of the nation's leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His 1968 article on the economics of moral hazard continues to serve as a benchmark in the medical insurance field concerning the effect of insurance coverage on the use of medical care services. He has analyzed Medicare and Medicaid financing, the impact of methods of paying health care providers on their behavior, and the role of employment-related group insurance.

C. Eugene Steuerle is a senior fellow at the Urban Institute, where he conducts extensive research on budget and tax policy, health care, Social Security, and welfare reform. In the area of health, he has published several articles on issues such as financing of health care, the use of mandates, and the economic effect of tax subsidies. Earlier in his career, he served in various positions in the Treasury Department under four different presidents and was eventually appointed deputy assistant secretary of the treasury for tax analysis.

Harry J. Conaway is a lawyer and the head of William M. Mercer's Washington Resource Group, which analyzes legislative and regulatory issues of importance to sponsors of pension and health plans. The group analyzes tax, ERISA, and employment law; assesses plan compliance with tax and other legal requirements; develops plan designs and administration strategies; and provides government relations assistance. Prior to joining Mercer, he was associate tax legislative counsel in the Office of Tax Policy of the U.S. Department of the Treasury. In this capacity, he represented the administration on major employee benefits legislation and worked on a variety of regulations affecting employee benefits.

Sonia Conly is a financial economist in the Office of Tax Analysis at the Department of the Treasury. She is primarily responsible for Treasury Department estimates of the direct and indirect effects on federal budget receipts of health policy changes. She has followed the literature and analyzed data on employer health insurance since the early 1980s.

John K. Meagher was named special counsel to the staff of the House Committee on Ways and Means in February 1998. His primary responsibilities are to coordinate work of the committee associated with "fundamental tax reform" and to serve as the committee's liaison to groups as part of its effort to abolish the income tax. Previously, Mr. Meagher was the managing director of the Tax and Trade Group at Cassidy & Associates, Inc., as well as a senior vice president of the firm. He served as Republican minority counsel to the committee from 1972 to 1981 and as assistant secretary of the treasury for legislative affairs in the Reagan and

Bush administrations. In 1991, he was appointed a member of the Advisory Council on Social Security.

James S. Ray is a name partner in Connerton & Ray, a law firm based in Washington, D.C., where he leads the employee benefits practice group. Mr. Ray's practice includes establishing benefit plans and labor-management organizations, counseling benefit plans, plan fiduciaries, and labor organizations, litigation, legislative representation, alternative dispute resolution, and negotiations.

ENDNOTES

1. Some advocates of reform would like tax incentives to encourage the purchase of health insurance on an individual basis (rather than through employment groups) as a means of empowering individuals and giving them more choice.

2. Bob Lyke, "Tax Benefits for Health Insurance: Current Legislation," *CRS Issue Brief*, Congressional Research Service, Library of Congress, Washington, D.C., updated September 3, 1998.

3. The CRS provides the following general formula for calculating federal income taxes. The list omits some steps, such as prepayments (from withholding and estimated payments) and the alternative minimum tax:

1. Gross income
2. *minus* Deductions (or adjustments) for AGI
3. = Adjusted gross income
4. *minus* Greater of standard or itemized deductions
5. *minus* Personal and dependency exemptions
6. = Taxable income
7. *times* Tax rate
8. = Tax on taxable income (regular tax liability)
9. *minus* Credits
10. = Final tax liability.

4. The concept of "tax expenditures" used by executive branch and congressional tax analysts is a specialized one. "Tax expenditures" are defined under section 3(3) of the Congressional Budget and Impoundment Control Act of 1974 (the "Budget Act") as "revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liability." According to "Estimates of Federal Tax Expenditures for Fiscal Years 1998-2002," prepared for the House Committee on Ways and Means and the Senate Committee on Finance by the staff of the Joint Committee on Taxation (December 15, 1997):

> Thus, tax expenditures include any reductions in individual and corporate income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers.
>
> Special income tax provisions are referred to as tax expenditures because they are considered to be analogous to direct outlay programs, and the two can be considered as alternative means of accomplishing similar budget policy objectives. Tax expenditures are most similar to those direct spending programs that have no spending limits, and that are available as entitlements to those who meet statutory criteria established for the programs.

Tax expenditure loss estimates do not necessarily equal the increase in federal revenues that would result if special tax provisions were repealed. There are many reasons for this, including that eliminating a tax expenditure may change economic behavior and that changes in one tax law may affect the impact of other tax laws, according to the "Budget of the United States Government, Fiscal Year 1999, Analytical Perspectives."

5. Executive Office of the President, "Budget of the United States Government, Fiscal Year 1999, Analytical Perspectives," Washington, D.C., 98.

6. Congressional Budget Office, U.S. Congress, "The Tax Treatment of Employment-Based Health Insurance," Washington, D.C., March 1994, 5.

7. Robert B. Helms, "The Tax Treatment of Health Insurance: Early History and Evidence, 1940-1970," draft chapter of "Health Care Reform: Solutions for a New Century," ed. Grace-Marie Arnett, (Galen Institute: Washington, D.C., forthcoming).

8. Mark Pauly, "An Efficient and Equitable Approach to Health Reform," draft chapter of "Health Care Reform: Solutions for a New Century," ed. Grace-Marie Arnett, (Galen Institute: Washington, D.C., forthcoming).

9. Sheila Smith, Mark Freeland, Stephen Heffler, David McKusick, and colleagues, "The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs*, 17: 5 (September/October 1998), 132.

10. "One-Third of Hispanics Uninsured, Census Findings Show," *Medicine & Health*, 52: 39 (October 5, 1998), 1.

11. Congressional Budget Office, "Tax Treatment," 8.

12. C. Eugene Steuerle and Gordon B. T. Mermin, "A Better Subsidy for Health Insurance," draft chapter of "Health Care Reform: Solutions for a New Century," ed. Grace-Marie Arnett (Galen Institute: Washington, D.C., forthcoming).

13. Paul Fronstin, "Features of Employment-Based Health Plans," *EBRI Issue Brief No. 201*, Employee Benefit Research Institute, September 1998, 3.

14. Under ERISA, health plan sponsors must assume fiduciary duties; adhere to reporting, information disclosure, and claims processing requirements; follow continuation of coverage rules; and adhere to a limited number of benefit mandates. Primarily designed to regulate private-sector pensions, ERISA contains no requirements for health plan solvency.

15. See Karl Polzer and Patricia Butler, "Employee Health Plan Protections under ERISA," *Health Affairs*, 16: 5 (September/October 1997).

16. Mark Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance* (Ann Arbor: University of Michigan Press, 1997), 95-96.

17. Pauly and many other economists argue that, in the long run, employees actually pay the cost of employer-provided fringe benefits in foregone wages, even though the benefits may appear to employees to cost them nothing.

18. Jill Foley, "Flexible Benefits, Choice, and Work Force Diversity," *EBRI Issue Brief No. 139*, Employee Benefit Research Institute, July 1993.

19. Ken McDonnell, Paul Fronstin, Kelly Olsen, Pamela Ostuw, Jack VanDerhei, and Paul Yakoboski, *EBRI Databook on Employee Benefits*, fourth edition (Employee Benefit Research Institute: Washington, D.C., 1997).

20. General Accounting Office, "Employment-Based Health Insurance: Medium and Large Employers Can Purchase Coverage, but Some Workers Are Not Eligible," GAO/HEHS-98-184, July 1998.

21. Congressional Budget Office, "Tax Treatment," 8.

22. The Consensus Group document notes that its contents reflect the views of these individuals and not necessarily their organizations.

23. Beth C. Fuchs, "Health Insurance Cost and Coverage: Tax System Approaches," *CRS Issue Brief*, Congressional Research Service, Library of Congress, Washington, D.C., updated December 3, 1996.

24. The nation's current tax and transfer structure already, in effect, imposes tax rates of as much as 70 percent or more on additional income for many people receiving Medicaid and welfare, according to Steuerle and Mermin.

25. Congressional Budget Office, "Tax Treatment," 33.

26. General Accounting Office, "Private Health Insurance: Estimates of a Proposed Health Insurance Tax Credit for Those Who Buy Individual Health Insurance," GAO/HEHS-98-221R, July 22, 1998.

27. Steuerle and Mermin, "Better Subsidy," 178.

28. Steuerle and Mermin, "Better Subsidy," 176.

29. See Lyke, "Tax Benefits."