Congressional Health Care Reform Education Project
October 28, 2008
House Event Summary

Sherry Glied of the Mailman School of Public Health at Columbia University began the session by providing an introduction and history of the tax treatment of health insurance. From the employer point of view, employee compensation paid in the form of health insurance is deductible as a business expense. From the employee perspective, it is not considered taxable income. Neither the employer nor employee pays Medicare or Social Security tax on the dollar value of the health insurance compensation.

She displayed the difference between an employee receiving wage compensation in the form of health insurance and an employee buying health insurance with post-tax wages to show the tax shelter provided by the tax exclusion. She explained the tax provisions related to flexible savings accounts, HRA/HSAs, and deductions for medical expenses.

Since 2003, Dr. Glied explained, self-employed people can deduct 100% of all health insurance premiums from net earnings; however they cannot deduct health insurance premiums from their Social Security and Medicare base. Flexible spending accounts (FSAs), also known as Section 125 plans, have existed since the 1980s and are offered by about a third of the private sector, and utilized by almost all employees who are given the option. HRAs and HSAs began in 2002 and 2004 respectively, allowing for tax-favored savings accounts in conjunction with high deductible health plans. Dr. Glied stated that encouraging out-of-pocket spending decreases health costs.

Dr. Glied explained that the tax exclusion of employer group coverage in 2006 cost the federal and state governments a total of $208.6 billion. This figure assumes that the money saved with the tax exclusion would otherwise be added to employees' wages. The history of the exclusion was then reviewed by Dr. Glied. In the 1940s the IRS ruled that health insurance premiums would be exempt from taxation. In 1953, the IRS decided that employer payments were taxable, but in 1954, Congress legislatively reversed the ruling. Since the early 1940s, enrollment in commercial policies has increased.

The favorable tax treatment for employer-sponsored insurance (ESI) is actually offered in most industrialized countries—with the exception of the United Kingdom since 1997—for the same reasons it is offered in the United States. Concerns exist in this system, however. The system is set up in a way that the benefits are not well targeted, nor are they progressive; benefits go to people who would have health insurance even without the tax benefit, while the benefits rise with those in higher tax brackets. When asked why the United Kingdom no longer has the tax exclusion, Dr. Glied said that while the majority of people get their health care from the National Health Service, many purchase supplemental coverage, and there has been some policy flip-flopping about whether the value of that supplemental coverage should be excluded from taxable income. Currently the value is not excluded.

Katherine Baicker of the Harvard School of Public Health then gave a presentation on ways we might want to change the tax treatment of health insurance, along with the pros and cons of doing so. Both public and private spending is rising, which provides the policy impetus for the consideration of changing the system. She believes that policy options

should focus on increasing the value of health care rather than on decreasing the costs. The variation in quality and spending are in some instances inversely correlated: higher spending does not necessarily lead to higher quality. Some reasons Baicker gave included: information on prices and quality is often not available; inefficient reimbursement exists within the public system; and the private system has an unbalanced and regressive tax treatment. Even though the average employer/employee contribution is 70%/30%, employees are still essentially paying for 100% of the costs, since the employer contribution is actually coming out of the wages workers would receive if they did not receive the health insurance compensation.

Baicker emphasized that, in addition to getting higher value for our health care spending, policy goals should focus on reducing inequities by spreading benefits more broadly, and making health care more affordable. According to Baicker, proposals for reforming the tax code should focus on how the tax treatment affects the employee. Options include a flat deduction, a flat credit, a refundable credit and a cap on employer exclusion. Dr. Baicker explained that the value of a tax credit is the same for all taxpayers, while the value of a flat deduction depends on the individual's tax bracket. She provided stylized examples of different tax systems with subsequent taxes paid for each plan. Dr. Baicker finished by reviewing how different groups in the population would fare with a change in the tax treatment of health insurance. Reforming the tax code is necessary but other concurrent reforms are required as well, Dr. Baicker explained.

Sherry Glied then provided her observations about tax policy options. Tax policy needs to be included in health reform efforts; however, she cautioned that the only broad-based private health insurance systems that have ever existed have been based on employer-sponsored coverage.

Dr. Glied explained the concerns that exist with the current tax subsidy: Those in higher tax brackets and more costly plans receive a larger direct subsidy, which encourages the purchase of employer-sponsored coverage rather than non-group coverage. Dr. Glied demonstrated, however, that there has been in recent years a relatively small decline in employer-sponsored insurance. It is difficult to refine the tax code to target the determinants of high health costs, since it is unknown if changing the tax code would affect only those with generous and at times excessive health plans, or also those for whom high health costs are a result of needed care.

Changing the tax treatment of health insurance does not necessarily mean that coverage would shift toward the non-group market. It is unclear how much it would change. But Dr. Glied asserted that the non-group market is inherently flawed. She also mentioned that it will be complicated to implement a tax treatment change.

Q & A Session

When asked if it would make sense for the employer-sponsored insurance (ESI) system, under new tax rules, to add subsidies for those individuals who use more health care, Dr. Baicker mentioned two related issues presented by the question. First, high administrative costs exist in the individual market. Second, the issue posed is related to underwriting. The premium one pays with ESI does not reflect their individual health status. When people wait until they are sick to buy into the individual market, the premiums will be higher for everyone.

When asked about how the tax credit option works logistically, Dr. Baicker discussed whether the government would pay checks directly to the insurers, or if checks would be sent to individuals every month or at the end of the year. The IRS would have to wrestle with these numerous options.

Dr. Glied said that an administrative nightmare might ensue if it were possible for an individual to choose whether they wanted either tax credits or ESI. Additionally, Dr. Glied said that individuals would choose the option that would be the most financially sound, therefore affecting the dynamic of risk pools.

When the option of capping the tax exclusion at a given level was mentioned, Dr. Glied said that the option would be difficult in the non-group market because costs are so high in the first place. Dr. Baicker then mentioned the viability of a risk-adjusted voucher that was based on the immutable characteristics of health. Of course, she said, it is difficult to do effective risk adjustment, but that it could be possible if the private health insurance system worked closely with some sort of government entity. Dr. Glied then made reference to the Dutch system, which has an individual tax credit with risk adjustment.