

Congressional Health Care Reform Education Project
October 28, 2008
Senate 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, 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.

Following Dr. Glied's presentation an audience member asked about why FSA uptake has been so slow. She noted that although there is tax advantage for paying higher premiums, a disincentive exists in the administrative hassle of setting up an FSA program, especially in reference to small employers.

Dr. Glied was asked to elaborate on the graph that depicts the long-term increases in enrollment in ESI plans. Dr. Glied said that it is an oversimplification to claim that the current system evolved the way it is because of the World War II wage and price controls

and the 1954 ruling that ended the tax exclusion for ESI. Other industrialized countries also implemented universal health insurance systems with similar tax treatment during the 1940s-1960s.

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.

Dr. Baicker emphasized that policy goals should focus on getting higher value for our health care spending, 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 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.

An audience member asked Dr. Baicker to comment on the possible resulting disruption of large firms in the event of tax treatment reform. Dr. Baicker said that the level of change will depend on the rules of the insurance market that are enacted.

An audience member also asked about the value of tax reform if it has worked to increase the number of people who are insured, but are actually insured against things that they do not need. Dr. Baicker responded by saying that the possibility of this scenario will depend on the underwriting of the tax treatment. She mentioned that the larger the credit, the more people will have insurance. Dr. Baicker then discussed her thoughts on risk-adjusted vouchers.

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 in recent years there has been 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. Dr. Glied explained that in 1993, Quebec withdrew the favorable tax treatment on health insurance. Employer coverage decreased 20%; 10-15% of that decline shifted to the individual market. When asked if data exists on the behavioral aspect of this change in policy, Dr. Glied said that there is no data available, but the Quebec experiment only lasted three years. She said that the psychology involved with educating the public on the changes in the system is important. She mentioned that it will be complicated to implement a tax treatment change.

Q & A Session

It was noted by an audience member that considering the large amount of geographic variation in the cost and quality of health care, a change in taxes would have a differential impact on different parts of the country. Dr. Glied said that it is unclear what to do about this, but it is clear that health care costs need to be controlled nonetheless. Dr. Baicker said that state-level policy could address this issue. She mentioned that the quantity of health care utilized – as distinguished from variations in price -- is a major variant in affecting costs.

Asked why the proposals for tax reform are limited to flat deductions and/or flat credits, Dr. Glied said that there are inherent administrative difficulties when a more complicated formula is considered. Dr. Glied said that within the Dutch system, for example, the risk-adjustment and the subsidies are separate components of the formula. At the same time, although the Dutch system is a private system, it is heavily regulated.

When asked about the Sen. McCain's proposed \$5,000 tax credit for a family, Dr. Glied mentioned that the option maintains the exclusion from income on which the payroll tax is paid, and that it is therefore not a revenue-neutral plan. Estimates of coverage changes vary widely. Some estimates indicate that 30 million individuals will take up insurance in the individual market under this plan, while 9 million individuals will lose their insurance because of the elimination of employer-sponsored insurance. Other estimates indicate that 10 million individuals could become uninsured.

Dr. Baicker stressed that system-wide changes will have even larger system-wide effects than ones touching only on prescription drugs, and projections of the effects can only be roughly estimated. Since the system has always been based on tax exclusions, we have no good evidence on which to base estimations of the impact of substantial change. An audience member added that changing the tax treatment of health insurance is politically difficult when there are no data about what the actual changes will be, especially when altering the tax exclusion would change the status quo within a system to which many people are accustomed.