1

Introduction

HENRY J. AARON AND LEONARD E. BURMAN

Following the collapse of President Bill Clinton's health reform proposal in 1994, most elected officials became unwilling to talk about major government action to change private health insurance arrangements. Democrats were shell-shocked by the political fallout from the Clinton debacle, to which some attributed the loss of control of both houses of Congress in 1994. Most Republicans were ideologically unsympathetic to federal tinkering with private health insurance decisions. And so for years both parties shunned the issue. No longer. Health system reform has once again become politically salient, consistently ranking among the top three issues in public opinion polls, along with the Iraq War and the economy.[1] Presidential candidates in both parties have put forward alternative visions of how to reform the delivery of and payment for health care services.

The reasons for renewed interest are straightforward. Health care spending has outpaced income growth for decades and in 2007 absorbed an estimated 16 percent of gross domestic product and approximately 25 percent of total federal outlays. Continuation of this trend would squeeze other government services, force massive tax increases, or balloon the federal debt. Unabated growth of private health care spending would also eventually seriously strain most household budgets. Partly because of rising costs, the number of Americans without health insurance of any kind has grown steadily. By 2006, 46.5 million (or 17.8 percent) of the population under age sixty-five were uninsured. If per capita health care costs keep growing faster than income, as the aging of the population and advances in medical technology make virtually certain, the number of uninsured will also continue to increase. Perhaps most galling, rapidly growing spending has not translated into consistently high quality. In fact, the quality of care even for the well insured is extremely uneven—superb for some but subpar for many.

Although elected officials may have taken a vacation from health system reform, analysts never did. The fledgling subdiscipline of health economics blossomed and matured. Among the shortcomings of the U.S. health payment system, to which these economists point, the current tax treatment is near the top. Under current law, premiums for employer-sponsored insurance (ESI) are excluded from both income and payroll taxes. The self-employed may deduct their premiums from income tax but not payroll taxes. But people who cannot get health insurance at work must pay their premiums out of after-tax income. The ESI exclusion thus favors employer-sponsored health insurance over all other forms of insurance as well as over other types of consumption expenditure.

The value of the ESI exclusion is large. Employers who pay a dollar in employee wages must also pay payroll tax for Social Security and Medicare—7.65 percent up to the Social Security taxable earnings ceiling, $102,000 in 2008, and 1.45 percent above that amount.[2] The employee must pay the same payroll tax as the employer as well as personal income tax. For a worker subject to the full Social Security and Medicare payroll tax and a 25 percent marginal income tax rate, the combined tax rate is 37.4 percent.[3] That means that added earnings that cost an employer $1 will pay for 62.6 cents worth of goods and services *other than health care* but for $1 of health insurance services. For a family whose insurance costs $10,000 a year, the cost of modest coverage in many communities, the tax subsidy for health insurance relative to other consumption with the same market price is $3,740. The favorable tax treatment is worth less to taxpayers who face lower marginal income or payroll tax rates and more to those who face higher rates.

The exclusion encourages employees to get health insurance at work if they can. And it means that at a given cost many employers can offer workers a more valuable compensation package if it includes health insurance than if it does not. There are exceptions. Some workers place little value on health insurance. And the costs to employers of administering health insurance—particularly those companies with rapid job turnover and that employ few workers—may exceed the value of the tax benefits and any premium discounts the employers might be able to negotiate.

Although employers may write the checks for health coverage, employees ultimately bear the burden in the form of lower wages, at least in theory. The theory is that employers decide how much expense they are willing to incur to hire workers and are largely indifferent to how that cost is divided among cash wages, health insurance, and other fringe benefits. Employers are assumed to be interested in hiring the best workforce that they can at a given cost. If workers want employer-sponsored health insurance because of the discounts available to

groups or because of tax advantages, employers will offer it, but they will not increase what they are willing to pay for a given workforce.

Employer sponsorship reduces the cost of health insurance to workers not only because of tax advantages but also because selling costs do not increase proportionately with the size of the group. Thus large employers incur lower average health insurance costs than do small employers. Furthermore, group insurance pools risks by covering the old and the young, the sick and the well, under one plan. That means that people with health problems do not face the very high premiums that they would confront if they had to buy insurance individually. For both reasons, employment is a natural base for insurance coverage.

However, the current system also has serious shortcomings. The tax advantage, for example, is poorly targeted. It is large for high-income filers, who need little help affording health insurance, and small or nonexistent for people with low incomes, for whom health insurance is unaffordable. Companies that employ disproportionate numbers of low-wage workers are therefore less likely to sponsor and pay for health insurance coverage than are companies employing higher-wage workers. The tax advantage for low-income, self-employed workers to buy insurance is similarly small. And the exclusion does not apply to nonworkers, regardless of income.

In addition, the tax advantage is costly. Relative to a system in which the value of employer-sponsored insurance is included in taxable compensation, the exclusion will reduce federal income tax revenues by $169 billion in 2009, more than one-quarter of federal spending on health care services. Other tax advantages accorded health care spending will reduce federal revenues by an additional $12 billion in 2009. There can be little doubt that a targeted system of incentives could promote health insurance coverage better than current tax provisions do.

Furthermore, the tax advantage is unlimited. Health insurance, however costly, is excluded from taxation as long as it is purchased by an employer or by a self-employed worker and as long as it qualifies under the broad definitions set by the Internal Revenue Service.[4] Because of this feature, the tax advantage encourages particularly generous coverage: low or no deductibles, low-cost sharing at the time health care is used, and coverage of services of comparatively low value. This feature weakens the price sensitivity of both health care consumers and health care suppliers and likely results in higher prices and greater use of services than would occur if the tax advantage were limited. In addition, this feature is thought to encourage costly technological changes rather than cost-reducing innovations, thereby fueling the rapid growth of health care spending.

The fact that health insurance is linked to a particular job means that insurance coverage can distort labor market decisions. When, say, a current job pro-

vides generous coverage, and the employee or a covered family member has an expensive medical condition, and a prospective job offers inadequate or no health insurance, the employee may be stuck in the job with the better health insurance. A worker who loses a job faces the prospect of also losing tax-free health insurance coverage, which can be especially costly to those with health problems that would make nongroup insurance prohibitively expensive.[5]

Political Initiatives to Fix the Problem

These shortcomings of the current tax treatment of health insurance have generated a range of reform proposals over the past quarter century.

The first plan to receive presidential support was put forward in 1983 during the presidency of Ronald Reagan. That plan would have kept the exclusion but capped it at $175 a month for family coverage and $70 a month for individual coverage. These caps are low by today's standards, but a quarter century ago they exceeded the premiums paid for almost all employees. However, the limit was to be indexed for general inflation, not for the more rapid increase in health care costs, in the correct expectation that the cap would gradually become binding as growth of health insurance spending and insurance premiums outpaced other prices, gradually forcing people to use after-tax, rather than before-tax, dollars to determine whether to buy more or less insurance. In other words, the tax treatment at the margin of income used to pay for health insurance would be the same as that of income used to pay for other consumption. Although congressional hearings were held on this proposal, it drew little support and languished. Had the plan been adopted, it would have ended one flaw of tax exclusion: the fact that it is open ended. But this shift in tax rules would not have dealt with the other problems. Notably, it would have continued to bestow the largest tax incentives on high-income filers and done little to help low- and moderate-income filers, who then as now constitute the bulk of the uninsured.

In 2005 President George W. Bush received recommendations from his Advisory Panel on Federal Tax Reform to renew the call for capping the tax exclusion of employer-financed health insurance. The panel proposed to cap the exclusion of employer-financed premiums at $11,500 a year for family coverage and $5,000 a year for single coverage. In addition, the panel proposed to end the income tax bias (but not the payroll tax bias) that favored group coverage through employers by allowing all filers to deduct from their taxable income the health insurance premiums that they themselves paid. The reason for this new provision was the belief held by some analysts that individuals would do a better job than employers in selecting insurance coverage that satisfied their wants and that insurance companies would offer a variety of plans to compete in this mar-

ket. Such competition, it was believed, would hold down premiums and, indirectly, the price and use of health care services. Furthermore, the exclusion was to be indexed for general price inflation, not for health care spending. This proposal, like the initiative during the Reagan administration, was controversial—and the Bush administration simply ignored the panel's recommendations.

In 2007 the Bush administration put forward a more imaginative plan. Premiums paid by employers would be imputed to individuals and treated as taxable income for both income and payroll tax purposes. However, taxpayers would be entitled to a deduction—$15,000 for couples filing jointly and $7,500 for individuals—if they were covered by approved health insurance. The deduction would be available whether filers received health insurance as a fringe benefit or bought it themselves, and the deduction would apply to payroll taxes as well as income taxes. Notably, the full deduction would be available even if insurance cost less, a provision that would encourage filers to shop for inexpensive coverage because the tax subsidy would not increase with spending. The objective of this plan was to end the tax bias in favor of employment-based coverage and to remove the incentive for overly generous coverage. Like President Reagan's cap proposal, the new standard deduction would be indexed to general price inflation rather than health inflation, putting downward pressure on health insurance spending over time.

Although the plan embodied a new idea, it suffered a familiar fate: failing to advance to the floor of either house of Congress. Critics assailed the plan because it did little to reverse the skew in favor of high-bracket filers and because it offered little or nothing to filers with too little taxable income computed after personal exemptions and other deductions to take full advantage of the health deduction. In fact, just as under the current system, the largest gains would accrue to those with the highest incomes. In addition, sick or older people faced a serious risk of becoming uninsured if employers dropped coverage because they would confront high premiums in the nongroup market and might be denied coverage altogether. If employers decided to drop coverage because their employees could enjoy the same tax benefits on their own as they derived from coverage through work, the poor health risks might encounter unaffordable premiums when they tried to buy insurance.

Whether and how to modify the tax treatment of health insurance also became a key issue in the 2008 presidential campaign. The Republican nominee, John McCain, proposed to grant tax filers a refundable tax credit of $5,000 for family coverage and $2,500 for single coverage for the purchase of health insurance either at work or in the individual nongroup market. As under the president's proposal, the value of employer-sponsored health insurance would be included in workers' taxable incomes, although it would remain

exempt from payroll tax. Unlike the Reagan and Bush plans, which depended on a deduction, Senator McCain's credit proposal would provide equal assistance regardless of income, a significant improvement. As under the president's proposal, some employers would likely stop offering coverage. Others might begin to offer it, as the fringe benefit would be more valuable to lower- and middle-income employees than the current exclusion is. The value of the credit would be indexed to general inflation, which means that it would cover a declining share of health costs over time. Like President Bush, Senator McCain expressed the intent to reform the individual nongroup market to help those with high health costs find affordable insurance, but as of this writing he has not indicated what measures he would support to achieve this objective.

The Democratic candidate, Barack Obama, has called for a system that would provide universal access to health insurance coverage. Income-related subsidies would help people afford health insurance. Insurance, private or public, would be available through a central insurance exchange that would administer subsidies and ensure that no one was denied coverage because of preexisting conditions. Senator Obama would mandate coverage for children but not for adults. Employers above a certain, unspecified size would be subject to a tax if they did not offer coverage. Small employers who offer insurance would quality for subsidies. His campaign literature did not specify the amounts of the subsidies or the penalty tax, nor the precise way in which the mandate for covering children would be enforced.

What Is Viable Policy?

The current tax treatment of health insurance is an accident of history and hard to defend. The practical question is how to change those incentives without jeopardizing coverage for the roughly 177 million Americans who are now covered by employment-based health insurance.

One key to successful health insurance is risk pooling, the combination of people in large groups, so that the potentially ruinous costs from serious illnesses are averaged over healthy and sick people. Roughly two-thirds of the variation in health care spending from year to year is random and unrelated to any identifiable personal characteristics. If the risks associated with such random variations are pooled, where each person pays an equal share of those costs, nearly everyone gains from the reduction in risk. In good years premiums are greater, and in bad years they are less, than the total cost of the health care they use, but these costs are never ruinous. This protection against insupportable financial loss is what insurance is all about. The remaining one-third of the variation in health care use is related to personal characteristics such as age, occupa-

tion, and personal medical history. Whether and how predictable risks should be shared is much more complicated and controversial.

Risk pooling can occur by requiring insurers to sell insurance to everyone and to charge everyone in large groups similar premiums. Alternatively, it can be achieved by tax-financed public subsidies that provide assistance to people with varying health insurance risks. In either case, subsidies are necessary to help those with low incomes afford insurance coverage. The current U.S. system encourages pooling at the place of employment for those who work. It pools the elderly and disabled through Medicare and the poor through Medicaid. Maintaining pooling is necessary to prevent very high insurance premiums for some people or the selective denial of access to care.

The current tax exclusion is flawed policy for the reasons already stated: it helps most those who need it least, it is fiscally burdensome, it may contribute to an undesirable increase in health care spending by encouraging some people to buy too much insurance, and it causes job lock. It is a very poor mechanism to help those who are currently uninsured gain coverage.

But simply repealing the current exclusion of employer-financed premiums is not a reasonable option. Many employers would drop coverage. Their workers would have to buy insurance in the nongroup market. Some would face premiums they cannot afford. Others might shortsightedly decide not to buy insurance and find themselves bereft of protection when illness strikes. So the question of what to do about the current tax exclusion has several parts: whether to cap the exclusion or to end it—and what to put in its place.

Capping the exclusion is an unsatisfactory option as it does nothing for low-income families and thus would not directly increase coverage. It would, however, increase revenues, which could be used to subsidize health insurance for those with low incomes. President George W. Bush's 2007 proposal to replace the exclusion with a deduction available to all who are adequately insured contains the kernel of a constructive reform by capping the benefit and delinking the incentive to buy insurance from the place of employment. It would become an attractive option if the deduction were converted to a refundable credit, perhaps related to income, and if it were linked to regulation of the individual health insurance market to ensure that coverage was available to all customers at affordable rates. Analysts debate whether these policies should be supplemented by one or more additional reforms. One reform could be a mandate requiring all people or selected groups to have insurance (to ensure that the healthy do not simply remain uninsured until they think they need coverage). Another could be public coverage of very large outlays (to protect insurance companies from very large losses, the threat of which could encourage them to compete primarily by attracting good risks and repelling bad risks).

History, Analysis, and Solutions

Because tax policy so strongly influences current health insurance arrangements, changes in tax rules are likely to be central to any meaningful health reform. Accordingly, the Urban Institute and the Brookings Institution, with financial support from the American Tax Policy Institute, commissioned the studies that form this volume. These chapters are divided into two sections. The first describes the current system in some detail and indicates why it needs to be reformed. The second part indicates some directions that reform might take.

The Current System and Why It Needs Reform

Robert Helms describes the origins of current tax policy and its influence on health insurance and health care spending. Modern U.S. health insurance originated in the 1930s partly as a response to the personal financial travail and the economic distress of hospitals during the Great Depression. Health insurance spread rapidly during World War II in large measure because wartime wage and price controls banned most increases in wage rates but allowed employers to liberalize fringe benefits such as health insurance. After the war, unions, which covered a much larger proportion of the nation's workforce than they do today, negotiated aggressively and successfully for employer-financed health insurance. Government extended health insurance coverage to the aged, disabled, and poor through Medicare and Medicaid, both enacted in 1965. Nonetheless, the numbers of uninsured began to increase. The rising cost of health care, generated by the proliferation of medical technologies and therapies and by the increase in insurance coverage itself, pushed up total health care spending, which made health insurance unaffordable for a growing number of Americans. Helms emphasizes the cost-increasing incentives of current tax rules and argues that these rules should be modified as part of any comprehensive reform of health insurance arrangements.

Leonard Burman, Bowen Garrett, and Surachai Khitatrakun describe current tax arrangements and the distortions that they generate. Still, they argue, pushing those currently insured through work into the nongroup market could be problematic because the nongroup market for health insurance suffers from a number of shortcomings. The market for health insurance, they argue, will not function adequately without significant government involvement. They provide data on the revenue cost of current health care tax incentives relative to an income tax system in which income devoted to health care was treated the same as income devoted to other (unsubsidized) forms of consumption. They document the regressive character of these incentives measured in absolute terms and in relation to per capita cost of health care spending. They explain some of the

problems that afflict the market for health insurance and conclude that the current exclusion of employer-financed health insurance from personal income and payroll taxes is both ill suited to promote insurance coverage and incompatible with a sensible definition of taxable income.

Lisa Clemans-Cope presents information about health savings accounts (HSAs). Up to age sixty-five people may deposit funds in an HSA if they are enrolled in a high-deductible insurance plan. Deposits, investment income, and qualifying withdrawals from an HSA are tax free, making these accounts more tax favored than any other form of saving available to households. Clemans-Cope points out that the combination of HSAs and high-deductible insurance should be particularly attractive to people with low expected health care outlays and comparatively high incomes. Low outlays facilitate the accumulation of large account balances, and high tax rates mean that being shielded from them is particularly valuable. For this reason, she argues, the combination of HSAs and high-deductible insurance may erode the pooling necessary to hold down private group insurance premiums by causing those who expect to spend little on health care to opt out of comprehensive insurance.

Henry Aaron, Patrick Healy, and Surachai Khitatrakun explain that HSAs are best regarded as an incentive for the purchase of high-deductible health insurance and as retirement saving incentives but argue that HSAs are poorly designed for either function. They report the experience of a medium-size company that offered a combination of HSAs and high-deductible insurance, a package that was financially more favorable than other insurance options. Nevertheless, only a minority of eligible employees enrolled. The authors indicate a number of possible reasons for this seemingly irrational decision, suggesting alternative incentives that might be more effective in encouraging the purchase of high-deductible insurance. They note that enrollment in HSAs and high-deductible insurance plans has been rather slow. In addition, HSAs are flawed tax policy, as they provide regressive opportunities to avoid tax, even by those who do no net saving.

Jessica Vistnes, William Jack, and Arik Levinson examine the effects of flexible spending accounts, which permit employees to direct a part of their earnings into a pool that is not subject to income or payroll taxes and from which out-of-pocket health care spending may be paid. These accounts extend the tax advantages of employer-financed premiums to out-of-pocket spending. The only drawback is that unused funds in these accounts are forfeited at year's end. Despite this risk, flexible spending accounts might encourage employees (and their employers acting on their behalf) to select insurance plans that have higher deductibles or larger copayments (fixed charges for health care) and coinsurance (percentage charges for health care) than would otherwise be the case. Data con-

firm this expectation only in part. Flexible spending accounts seem to boost coinsurance rates slightly, but they are not associated with increases in deductibles or copayments.

Mary Hevener and Charles Kerby, two attorneys who have specialized in the legal and administrative aspects of health plans and compensation tax issues, describe a number of legal and technical problems with the current tax administration. They present a primer on current rules governing flexible spending accounts, group and individual health plans, HSAs, COBRA health benefits (an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985) for workers who leave employment in which they were insured, and the health coverage tax credit, which is available to some workers judged to have lost employment because of international trade. They recount the IRS's history of administering— or failing to administer—these and other provisions, including notably the requirement that health benefits not discriminate in favor of highly compensated workers. They conclude that if the IRS is given sufficient resources and the public is prepared to accept some amount of administrative failure, the agency could, in principle, manage the various tax-based reforms now under consideration. But they argue that nontax approaches to finance and administer an extension of health insurance coverage might be better.

Directions for Reform

Janet Holtzblatt brings her long experience with the Treasury Department to her consideration of the problems that the Internal Revenue Service will have to solve if it becomes the agency charged with administering laws to reform the financing and delivery of health care insurance. The first problem is how to reach a targeted population with subsidies without very large increases in compliance burdens and administrative costs. The second is how to enforce a mandate and eligibility rules for a subsidy without increasing noncompliance with this provision and with other aspects of the tax system. The third challenge arises from the fact that final income tax returns are not due until well after the end of the year for which they are computed. This delay works acceptably for taxes but would not be tolerable for the enforcement of mandates to carry health insurance or for the delivery of subsidies for health insurance that people must have continuously. She then examines specific plans for using tax policy to reform the tax system from the standpoint of their enforceability.

Jason Furman emphasizes that health system reform should be designed to make at least some progress on each of the three major problems with current health care arrangements: too many people are uninsured, health care is costly but much of it produces negligible benefits, and Medicare and Medicaid threaten to produce insupportable budget deficits. Any proposal that exacer-

bates any of these problems should be rejected, Furman argues. He especially indicts two proposals: the extension to all health care spending of the current exclusion from income and payroll taxes of health insurance premiums paid by employers; and the extension of deductibility to include all premiums for non-group insurance. Although these proposals would equalize tax treatment of health insurance paid in different ways—a plus in terms of fairness—each moves in the wrong direction with respect to equalizing the taxation of income used for health care versus income used for other purposes, and each would aggravate projected long-term budget deficits. Furman advocates an alternative package of reforms, including income-related, refundable, and advanceable subsidies for the purchase of insurance; an individual mandate or automatic enrollment; the creation of a new organization, much like one recently created in Massachusetts (the Health Connector), to pool large numbers of people for insurers; and publicly managed reinsurance to guarantee that affordable insurance is available to those at high risk while keeping premiums reasonable for those in good health.

Jeffrey Liebman and Richard Zeckhauser apply insights from behavioral economics, a recently developed field that incorporates findings from social psychology and sociology, to modify some of the basic assumptions of traditional economic analysis. People routinely make mistakes in coping with improbable or uncertain events. They tend to overweight current costs and underweight future benefits. They shy away from thinking about bad outcomes. And they are unable to rank in a consistent way objects that embody complex and diverse attributes. They stick with the status quo, even when they would not choose it if they were making the choice anew. Their decisions are heavily influenced by default options, even when the cost of changing them is miniscule. Liebman and Zeckhauser explain why all of these cognitive frailties come into play in making decisions about health insurance and the use of health care services. They argue, for example, that some of these mental traits justify subsidies for health insurance and for insuring inexpensive health care episodes for which people can easily afford to pay without help. The potential importance of these warnings is underscored by recent research that finds that giving care away for free or even paying patients to use the care can reduce the long-run cost of treating some conditions. Examples include screening for blood sugar in diabetics and some drug regimens for chronic illnesses.

The book concludes with comments from Peter Orszag, Congressional Budget Office director, on the sources of high per person health care spending in the United States, the means of slowing the growth of this spending, and the reasons that such a slowdown need not compromise the quality of health care.

Notes

1. See, for example, the Kaiser Health Tracking Poll, March 2008 (www.kff.org/kaiserpolls/upload/7752.pdf).

2. In addition, employers levy unemployment insurance taxes at rates that vary from state to state. Generally, the cap for such taxes is quite low—under $10,000 in more than half of states—and thus we ignore the effect of such taxes in the rest of the book.

3. The combined tax rate is computed as follows: let s equal the payroll tax rate applied to employers and employees and t equal the marginal income tax rate. The employer's cost of an additional dollar of cash wages is $(1 + s)$, while the employee nets $(1 - s - t)$. The effective tax rate is $1 - [(1 - s - t)/(1 + s)]$, which can be simplified as $(2s + t)/(1 + s)$. For a payroll tax rate of 7.65 percent on both worker and employer and a 25 percent personal income tax rate: (2*0.0765 + 0.25)/1.0765 = 0.374.

4. Technically speaking, the exclusion is not unlimited. Although group insurance premiums above $50,000 a year are not excluded from tax, this limit is so high that it has little bearing on the insurance choices under any group plan.

5. The Consolidated Omnibus Budget Reconciliation Act of 1985 allows terminated workers to purchase insurance from their employers for no more than 102 percent of the average premium in the firm. However, this cost, which is not eligible for the tax exclusion, can be a great financial burden for someone who has lost a job. Workers who have had ESI are guaranteed nongroup insurance under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), but that insurance is typically much more expensive than insurance that a healthy person could purchase.