STATEMENT OF ROBERT GREENSTEIN
EXECUTIVE DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES

for the

SENATE COMMITTEE ON FINANCE

ROUNDTABLE ON FINANCING

May 12, 2009

Thank you for inviting me to discuss health care reform financing issues. This is an important aspect of health care reform.

Financing is Critical

Some 46 million Americans are uninsured, a problem that other western industrialized nations have been able to address. In addition, rising health care costs threaten the nation's long-term fiscal and economic health. If health costs per beneficiary simply rose at the same rate as per capita economic growth, rather than growing considerably faster, nearly three-fourths of the massive long-term fiscal gap we face would be closed.

There is a strong argument that national health care reform should be our highest domestic priority. And, if it is this important, then it is worth paying for. Moreover, given the deeply problematic fiscal outlook, we should pay for the upfront costs of health reform.

I commend the Committee for devoting a full roundtable to financing.

No Easy or Painless Answers

I wish there were a number of painless options. There aren't. As you well know, some types of improvements in health care hold promise as ways to slow health care cost growth, but either we don't have firm knowledge about the savings they would produce or the savings would be unlikely to materialize on a substantial scale for a number of years. In other words, these initiatives don't "score."

To finance badly needed health care reform, all sides will need to make sacrifices. Tough measures will be needed — on both the spending and the revenue sides of the budget.

Moreover, the number of spending and revenue offsets that will be needed is likely to be substantial. There appears to be no single option that is politically viable and that can, by itself, produce most or all of the savings needed.

This leads to my first recommendation, in the form of a plea to the Committee. Please do not take any offset options off the table at this time. I believe you ultimately will need to put together a

package that contains an array of spending and revenue offsets. The more that options are taken off the table now, the harder this will be to do. You will need to make tough choices in a number of areas. If Congress can step up to the plate and put together a package of offsets that pay for health care reform legislation — and health care reform then is enacted — the nation will benefit greatly for decades to come. If this occurs, you will go down in history for your foresight and your courage.

I would like to divide my statement into two sections — one discussing spending offsets and the other discussing revenue offsets. Given the importance of this legislation, I don't think options should be limited to those that are directly health related. Particular attention should be accorded, however, to those options that would not only produce savings to help finance health reform but also improve the U.S. health care system by slowing health care cost growth, curbing the use of unnecessary care, or improving the health of our people.

Spending Offsets

The President's budget proposes a series of reforms in health care programs, primarily in Medicare, that CBO estimates would save $295 billion over ten years. Many of these reforms are consistent with the findings and recommendations of Congress' Medicare Payment Advisory Commission (MedPAC). These proposals merit serious consideration.

- They would produce substantial savings to help finance health care reform.
- A number of these measures also could lead to cost-saving reforms in the *private* sector, as private insurers followed Medicare's lead in such areas as the bundling of payments, reducing hospital readmissions, and basing provider payments on quality of care.
- In addition, these reforms would help strengthen Medicare's finances, wh*ich bad*ly need shoring up for the long term.

These proposals thus would yield a triple benefit.

A newly released survey of health care leaders conducted by the Commonwealth Fund found strong support for these proposals. Large majorities of the health care leaders surveyed voiced approval of eight of the nine Administration Medicare proposals they were asked about.

In its March 2009 report to Congress, MedPAC issued several additional Medicare recommendations related to other provider payment rates that would generate savings. These should be considered as well.

Additional Medicare and Medicaid Proposals that Would Produce Savings

The Finance Committee explored a number of Medicare proposals in its roundtable on health care delivery reform and discussed some of these in the paper it produced following that roundtable. Let me suggest consideration of three additional savings proposals — two in Medicaid and one in Medicare.

1. Delivery system reforms in Medicaid

As noted, the Administration and MedPAC have proposed various Medicare delivery system reforms. Congress could consider applying these similar delivery system reforms in Medicaid as well, where that is appropriate.

State Medicaid programs could be encouraged to establish bundled payments and to structure their Medicaid payments to reduce hospital readmission rates. The federal government also could facilitate the further use of pay-for-performance both in Medicaid fee-for-service and in Medicaid managed care. In addition, states could be encouraged to institute promising care-management programs for certain high-risk populations, including high risk pregnant women (to reduce the number of neonatal intensive care unit admissions), children with asthma, and people with chronic illnesses. Finally, more state Medicaid programs could be encouraged to limit Medicaid payment for medical conditions acquired during stays in a hospital; this is already required under Medicare and in some state Medicaid programs.

2. Lowering the Cost of Medicaid Drug Coverage

Congress could take steps to lower federal costs for drugs prescribed under Medicaid. This could be done through several measures.

First, the minimum Medicaid drug rebate could be increased.

Second, the rebate could be applied to drugs dispensed by Medicaid managed care plans. Drug manufacturers currently are not required to pay rebates on drugs dispensed to beneficiaries enrolled in Medicaid managed care plans. This exception was based on the assumption that managed care plans could negotiate discounted drug prices as favorable as those required under the Medicaid drug rebate. However, recent evidence shows this likely is not the case.[1] Applying the Medicaid drug rebate to drugs dispensed through managed care plans would ensure that these plans get the best prices available, and it would allow the federal government and the states to achieve savings in their managed care capitation rates.

Both of these proposals to secure savings in Medicaid were passed by the Senate in 2005. Both also are included in President Obama's budget (and are reflected in the $295 billion in savings referred to above that CBO estimates the President's proposals would produce).

Several other steps also could be taken that would yield additional savings. Manufacturers of *brand-name* drugs are required to pay additional rebates under Medicaid if prices for those drugs rise faster than the Consumer Price Index. The Office of Inspector General at the Department of Health and Human Services has recommended applying a similar rebate adjustment to *generic* drugs.[2]

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[1] Center for Health Care Strategies, Inc., "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Settings," January 2003 and The Lewin Group, "Extending the Federal Drug Rebate Program to Medicaid MCOs: Analysis of Impacts," May 2003.

[2] Daniel Levinson, "Review of Generic Drug Price Increases," Office of Inspector General, Department of Health and Human Services, October 2007.

The federal government could also encourage states to adopt Medicaid best practices in managing their prescription drug costs. Some states conduct periodic reviews of prescription drug usage, particularly among high users, to ensure that the drugs prescribed are medically necessary and thereby to limit fraud and abuse and improve patient safety. These states also monitor prescribing patterns by physicians and initiate general provider education efforts known as "counter-detailing" or "academic detailing," which have been shown to reduce costs that stem from inappropriate prescribing. Some states intervene with specific providers who prescribe an unusually high number of prescriptions.[3]

3. Reducing Costs for Drugs Prescribed through Medicare to "Dual Eligible" Beneficiaries

Prior to the establishment of the Medicare Part D drug benefit, *Medicaid* provided prescription drug coverage to more than 6 million "dual eligibles" (low-income Medicare beneficiaries who also are enrolled in Medicaid). In 2006, drug coverage for these dual eligibles was shifted to Medicare. When Congress enacted the drug benefit, it assumed that the private insurers participating in Part D would be able to negotiate greater rebates from drug manufacturers than the rebates the manufacturers had been required to pay, under Medicaid, for drugs dispensed to the dual eligibles.[4]

An increasing body of research demonstrates, however, that the rebates negotiated by Medicare Part D plans actually are well below the rebates that would have been required under Medicaid. As a result, the federal government is now incurring higher drug costs for the dual eligibles than it previously incurred under Medicaid.

Harvard health economists Richard Frank and Joseph Newhouse examined SEC filings among manufacturers of drugs used heavily by dual eligibles, such as anti-psychotic medications. They found that that Medicare Part D plans were *not* obtaining prices that approximated the prices for these drugs net of the Medicaid rebates. As a result, they found "manufacturers have realized significant gains simply from the change in responsibility for purchasing from Medicaid to Medicare."[5]

Similarly, Stephen Schondelmeyer, a University of Minnesota expert on prescription-drug pricing, has estimated that most of the publicly released Medicare Part D prescription drug prices are *20 to 30 percent higher* than the estimated prices in Medicaid net of the manufacturers' rebates.[6] In addition, in a July 2008 report, the majority staff of the House Committee on Oversight and Government Reform found that had the dual eligible beneficiaries remained in Medicaid in 2006 and 2007, the

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[3] See Jeffrey Crowley and Edwin Park, "Advancing Efficient Management and Purchasing of Prescription Drugs in Medicaid," Center for Children and Families at the Georgetown University Health Policy Institute, March 2008.

[4] Under Medicaid, drug manufacturers must pay rebates for drugs dispensed to Medicaid beneficiaries equal to the higher of a minimum statutory rebate (15.1 percent of the Average Manufacturer Price) or the "best price" or discount provided to any private purchaser.

[5] Richard Frank and Joseph Newhouse, "Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing," The Hamilton Project at the Brookings Institution, April 2007. See also Richard Frank, Testimony before the U.S. Senate Committee on Finance, January 11, 2007.

[6] Stephen Schondelmeyer, Statement before the Minority Office of the House Committee on Government Reform Briefing on the Medicare Drug Plan, January 20, 2006.

federal government would have saved $3.7 billion on the 100 drugs most often used by this population.[7] This figure was derived from the Committee's review of confidential pricing documents provided by insurers and drug manufacturers at the Committee's request.

To help finance health reform and lower Medicare costs, Congress could require drug manufacturers to provide, at a minimum, the same level of rebates for prescription drugs provided to dual eligibles under Medicare Part D as would have been required under the Medicaid program. There is no Congressional Budget Office estimate for this policy option, but the House Oversight and Government Reform Committee staff estimated it would produce savings of as much as $86 billion over ten years.[8]

Chairman Baucus' "white paper" on health reform stated that Congress should consider extending the Medicaid price discounts to Part D-covered drugs dispensed to the dual-eligible population.[9]

Revenue Offsets

This part of my statement covers four types of revenue options:

1. Capping the tax exclusion for employer-sponsored health care
2. Other health-related tax expenditures
3. Health-related excise taxes
4. Capping itemized deductions for high-income filers

Let me preface this discussion by noting that while these options would raise revenues, health care reform likely also will include tax credits to make health care affordable and enable an individual mandate to be put in place. The tax code currently features extensive spending on health care, with the tax code being used as the delivery system for these subsidies. Debate over reforms in this area should seek to avoid old ideological battles and simplistic dismissals or endorsements of options as "tax increases" or "tax cuts." The primary goal here is to reform health tax expenditures to make them more efficient and effective, more conducive to restraining health care costs, and less regressive.

1. The Employer Exclusion

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[7] House Committee on Oversight and Government Reform, Majority Staff, "Medicare Part D: Drug Pricing and Manufacturer Windfalls," July 2008, http://oversight.house.gov/documents/20080724101850.pdf.

[8] In 2006 and 2007, covering the top 100 drugs used by dual-eligible beneficiaries cost an average of 30 percent more in Medicare Part D than it would have in Medicaid. The cost estimate cited here assumes that the price differential would remain at 30 percent over the next ten years and applies that differential to all drugs that the dual eligible beneficiaries are expected to use. See House Committee on Oversight and Government Reform, *op cit.*

[9] Senator Max Baucus, "Call to Action, Health Reform 2009," Senate Finance Committee, November 12, 2008.

The employer tax exclusion is the single largest subsidy in the tax code. According to the Joint Committee on Taxation, the exclusion of employer-sponsored health care reduced federal tax collections by $246 billion in 2007.[10]

As is well known, the tax exclusion is poorly targeted. It gives the greatest benefit to those with the highest incomes, although they are the group that least needs help paying for health insurance. The 24 percent of tax units with incomes over $75,000 in 2004 received almost half of the benefits of the exclusion, while the 27 percent of tax units with incomes under $20,000 received 6 percent of the benefits.[11] This result arises for three reasons: (1) low- and moderate-income people are less likely to have jobs that offer health insurance; (2) low- and moderate-income individuals offered employer-sponsored insurance are less likely to participate than people at higher income levels, because they cannot afford to pay their share of the premiums; and (3) people with modest incomes benefit less from the tax exclusion than people at high income levels because they are in lower tax brackets.

The tax exclusion also exacerbates the problem of high and rising health care costs. Like any subsidy, the exclusion encourages more spending on the item that is subsidized. By reducing the after-tax price of health insurance, the exclusion provides an incentive for employers and individuals to select more generous coverage than they otherwise would purchase. Along with other factors, this leads to an increase in the demand for health care services, drives up prices in the health-care sector, and ultimately makes health care and health coverage less affordable.[12]

Because of these problems, many analysts have recommended that the tax exclusion be scaled back. Capping the tax exclusion at some dollar level could change incentives in ways that would encourage people to seek, and providers to practice, more cost-effective health care and thereby slow the growth in health care costs.

But there also are legitimate concerns about such a course. Unless limits on the tax exclusion are combined with other changes, modifying the exclusion could weaken employer-sponsored insurance, which is the predominant source of health coverage for people of working age and their dependents. The tax subsidies provided through the exclusion are a primary reason why employer-based coverage is so widespread, along with the economies-of-scale and the risk pooling function that employer-based coverage provides.

What to Do?

A cap on the tax exclusion could make an important contribution to health-care reform by providing a significant source of financing without eroding employer-sponsored insurance or

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[10] The estimate assumes that if the exclusion for employer-sponsored insurance were repealed, employees would not be permitted to deduct the premiums as medical expenses. If such behavior were permitted, the cost of the exclusion would fall to about $200 billion a year.

[11] Leonard E. Burman, Bowen Garrett, and Surachai Khitatrakun, "The Tax Code, Employer-Sponsored Insurance, and the Distribution of Tax Subsidies," in Henry J. Aaron and Leonard E. Burman, *Using Taxes to Reform Health Insurance* (Washington: Brookings Institution, 2008), p. 43.

[12] JCT, *Tax Expenditures for Health Care,* p.12.

causing other undesirable effects — if both the cap and the rest of the health care legislation are well designed. The design issues are crucial.

First, most health-reform proposals include a requirement that individuals obtain health insurance for themselves and their families. This is important: faced with having to meet an individual requirement, many workers would find employer-sponsored health insurance even more attractive than it is now even if part of the benefit effectively became taxable for a minority of workers. Employers would have every reason to continue offering health insurance, and employees would have every incentive to accept the offer. In Massachusetts, the individual mandate has resulted in an increase in employer-sponsored coverage.

Second, some health-reform proposals also include a requirement that employers of more than a certain size offer insurance to their employees or pay some sort of charge. Such a requirement — commonly called "play-or-pay" — would discourage employers from dropping health insurance coverage if it became partly taxable for some people.

Third, appropriate adjustments in the cap could be made. Since critics of capping the tax exclusion have correctly observed that the premiums for the insurance that some firms offer may be high *not* because a plan provides particularly generous benefits but because 1) the covered workers are located in an area with high health-care spending or insurance costs, 2) the covered workers are older or sicker than average, or 3) the firm is of smaller size and a greater portion of the premium is attributable to administrative costs than is the case for larger firms.

Some of these concerns can be addressed by other components of health reform — in particular, by barring insurers from continuing to vary premiums based on beneficiaries' health status or on firm size. The other concern can be addressed by building appropriate adjustments into the cap itself. The cap could be adjusted based on a firm's location and the age of its workforce, so that workers would not pay more because they live in an area with higher-than-average health costs or because their firm has an older workforce. The IRS could issue a set of geographical adjustment factors. If a new system of health insurance exchanges is established, the geographic areas used to adjust the tax cap could correspond to the areas used to set premiums within the exchanges.[13]

Structuring a Cap

A cap could be based on the cost of insurance. Under this approach, only contributions to the most expensive insurance plans would be taxable. Contributions that employers and employees make for health insurance and health care costs would be included in taxable income only if, and only to the extent that, they exceeded a certain amount (which as noted, could be subject to several adjustments).

Alternatively, a cap could be based on the income of the taxpayer. Under this variant, only people with incomes above a certain threshold would face taxation on their employer's contributions to the cost of their health insurance.

[13] The IRS could be directed to issue a set of geographic adjustment factors that firms would apply to the raw premium amounts in order to determine the amounts reported on W-2 forms. Appropriate modifications could be made for firms whose workforce is spread over several locations.

Or, a cap could be based on both the amount of the insurance and the income of the taxpayer. Under this approach, only upper-income taxpayers whose tax-favored health contributions exceeded a certain amount would be subject to the cap.

If properly designed, a limit on the tax exclusion for employer-sponsored insurance could be administered in an equitable fashion and without imposing large compliance burdens on employers or workers,[14] could contribute significantly to financing health care reform, and could be a useful tool in helping to restrain health care costs.

2. Other Health-related Tax Expenditures

The tax code contains a plethora of tax expenditures that have been added in piecemeal fashion over the years, primarily to help people afford insurance or moderate their out-of-pocket costs. Some of these provisions would be unnecessary or duplicative under a reformed health insurance system. In addition, continuation of certain tax expenditures would be counterproductive because these tax breaks encourage unnecessary and wasteful health care spending. Continuation of some other tax expenditures could weaken a new system of health care exchanges by fostering adverse selection (the separation of healthy and less-healthy people into different insurance arrangements). Finally, current health tax expenditures tend to be highly regressive.

Accordingly, reform of these health tax expenditures could provide a source of financing for health care legislation while strengthening a reformed health care system that seeks to extend coverage and restrain health care costs.

A comprehensive assessment of health tax expenditures lies beyond the scope of this testimony. I will cover three such tax expenditures here: flexible spending accounts, the itemized deduction for health care costs in excess of 7.5% of adjusted gross income, and health savings accounts.

Flexible Spending Accounts

Individuals with access to flexible spending accounts may elect to have a portion of their wages or salaries placed in such an account, with that income being exempt from income and payroll taxes. Individuals then withdraw funds from the account (by submitting claims to their employer or to a firm with which their employer has contracted to manage the account) in order to secure reimbursement for out-of-pocket health costs for deductibles, co-payments, and elective health care costs and health-related products that their insurance does not cover.

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[14] Different approaches would be required for employers who purchase insurance and firms that self-insure. Small employers generally purchase insurance from an insurance company and pay a clearly identifiable premium to an insurer for each employee and dependent. Employers could easily report the current premium amount, or a specified portion thereof, on workers' pay stubs and W-2 statements. Large employers generally act as their own insurer and do not actually pay premiums to an insurance company. Such self-insured employers, however, must calculate premiums charged to former employees eligible for continuation of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). These employers could report the most recently determined COBRA premium (excluding the additional 2-percent administrative charge), or a specified portion, for the employee's coverage type (individual, family, individual plus spouse, or individual plus child) on workers' pay stubs and W-2 statements. See Paul Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers*. Washington: Employee Benefit Research Institute, January 2009. EBRI Issue Brief No. 325.

FSAs are designed to make health care more affordable. If a reformed health care system provides access to affordable coverage, however, with subsidies for people who need such assistance with the costs (and possibly with an out-of-pocket limit, perhaps set as a percentage of income), FSAs should not be essential.

Moreover, FSAs have several undesirable effects.

- The accounts directly encourage excessive and unnecessary health care spending. FSA accounts thus create incentives at odds with health reform goals. People who have these accounts lose all of the wages or salaries remaining in them at the end of the plan year. This prompts bursts of year-end spending on health items and elective procedures that people otherwise would not purchase. People purchase those items and procedures at the end of the year because the items and procedures seem free under FSAs' "use it or lose it" nature.

- The accounts subsidize utilization of health care services and items not typically covered by health insurance. While some of these services may be medically necessary and cost-effective, other services purchased may be elective and of little value. This aspect of FSAs, as well, encourages excess health care spending.

- FSAs are highly regressive and provide only modest benefits to most people of ordinary means who use them;

- FSAs are time consuming to use, involving considerable paperwork with a host of small receipts (in economists' terms, the "transaction costs" imposed on individuals who use these accounts can be considerable);

- Finally, FSAs actually hurt some low- and moderate-income workers. The Tax Policy Center reports that for lower-income people, the eventual loss in Social Security benefits due to lower payroll tax contributions as a result of FSA participation generally outweighs the immediate tax savings. People affected in this way usually have no idea that they are lowering their lifetime disposable income by participating in an FSA.

Consider the following. The average contribution to a FSA was $1,208 in 2006. Someone in the 15 percent tax bracket would get a tax savings of approximately $270 if he or she contributed this amount — but, the typical benefit for middle-income households is less than this because people at higher income levels tend to place larger amounts of money in FSAs, thereby boosting the average contribution up to the $1,208 level just mentioned. The typical middle-income participant contributes less than $1,208. And to gain these relatively modest tax benefits, individuals generally must spend hours stockpiling receipts and filling out forms. Finally, Aetna found that 14 percent of its FSA customers *forfeited* an average of $723 in 2007 because of funds that remained unspent in FSA accounts at the end of the year.

That FSAs encourage excessive health care spending is undeniable. The following advice from the "Frugal Dr. Mom" website in promoting a humidifier is illustrative: *"If you have FSA money to burn, humidifiers generally count as an FSA purchase."* Or this from the "planforyourhealth" website: *"If you have an FSA, spend that money!"*

Moreover, FSAs encourage spending on types of health treatments or volumes of procedures that are beyond recommended medical practice and are not covered by insurance. In a world where insurance coverage can be flimsy, the case for FSAs is stronger, though not compelling. With health care reforms that set standards for creditable coverage and involve subsidies and some type of limit on out-of-pocket costs, the case for FSAs is much weaker.

In short, FSAs are labor-intensive for taxpayers but yield only modest tax savings for most participants. They are regressive and distort consumption choices in a wasteful direction, both because they can be used for health care services *irrespective* of cost-effectiveness or clinical effectiveness, and because the "use or lose it" feature of FSAs encourages people to make unnecessary purchases at the end of the plan year. And well-designed health care reform would remove much of the rationale for health FSAs.

The preferred option would be to eliminate health care FSAs at the time that the reformed health care system takes effect. Other options include imposing an annual FSA contribution limit (e.g., $1,000), setting an income limit on FSA participation (e.g., at the income limits used for deductible IRAs), and including FSAs under a cap on employer-related health care subsidies (i.e., instead of a cap on employer health care contributions, placing a cap on total tax benefits associated with employer-sponsored coverage.)

A related issue concerns the current tax expenditure for the employee share of health care premiums for employer-sponsored insurance, which also can be paid out of pre-tax income that isn't subject to income or payroll tax. If the employee share of the premium is $100 a month, a high-income individual effectively pays $64 because of this tax expenditure, while an employee in the 10 percent tax bracket pays $82. (These figures reflect the effect on the employee share of the payroll tax as well as the income tax.) One option is to fold this tax benefit into an overall cap on the tax benefits associated with employer-based coverage.

The Tax Deduction for Costs Exceeding 7.5% of AGI

The tax code helps to protect people against catastrophic health care costs by providing a deduction for health costs that exceed 7.5% of AGI. This deduction may no longer be needed in full under health care reform, depending on the shape that reform takes.

If benefit packages are adequate, subsidies are provided to people of modest means, and there are reasonable limits on total out-of-pocket costs, this deduction should no longer be needed — with one important exception. The deduction will continue to be needed for long-term care costs. (A refundable tax credit would be superior to a deduction for long-term care costs, but that lies beyond the scope of this testimony.)

Health Savings Accounts

Health Savings accounts are another tax mechanism that is intended to help make health care costs more affordable but would not mesh well with a reformed health insurance system. HSAs could make a system of health care exchanges less effective and efficient. Also of concern, some features of HSAs may foster excess health care consumption.

A particular concern about Health Savings Accounts attached to high-deductible health insurance plans is that such plans can pose a significant risk of "adverse selection," because they tend to be disproportionately attractive to healthier and more affluent individuals who do not need much in the way of health care and consequently are less concerned about the higher out-of-pocket costs required under a high-deductible plan, but who benefit the most from the unprecedented tax-sheltering benefits that HSAs provide.[15] (Unlike any other tax-preferred savings account in the tax code, contributions to HSAs are tax-deductible *and* withdrawals are tax free if used for out-of-pocket medical expenses. Other accounts, like IRAs, permit deductible contributions but tax the withdrawals or allow tax-free withdrawals but do not allow tax-deductible contributions.)

If high-deductible plans attached to HSAs can be offered within the new health insurance exchanges and significant numbers of healthier-than-average individuals enroll in such plans, that likely will drive up premiums for the more comprehensive plans offered in the exchanges since those plans would tend to be left with sicker-than-average groups of enrollees. As a result, the federal government would *either* have to increase the subsidies available to enable lower-income individuals, particularly those who are in poorer health or have chronic illnesses, to continue enrolling in comprehensive plans, *or* such individuals would be forced to enroll in HSA plans even though such plans require substantial upfront deductibles and other cost-sharing that low-income individuals generally are not able to afford.

Options for how to deal with these issues as part of health care reform include the following:

- Bar high-deductible plans attached to HSAs from being offered in the exchanges. As noted, such plans are likely to lead to adverse selection within the exchanges, which would lessen the ability of the exchanges to pool risk effectively over the long term and provide broad access to affordable, comprehensive coverage.

- Limit HSAs' tax-sheltering benefits, at least for HSAs offered through the exchanges. In the version of their health reform plan that Senators Wyden and Bennett offered last year and presented to the Congressional Budget Office for evaluation, individuals enrolled in HSAs would no longer be permitted to make tax-deductible contributions to HSAs and thereby to use HSAs in substantial part as tax shelters. The only contributions allowed would be those made by insurers to comply with an actuarial value standard required of all health insurance plans. Such HSA reforms would make HSAs less disproportionately attractive to healthy, higher-income individuals and thus would moderate the risk of adverse selection that HSAs would otherwise pose to the exchanges, although some risk would remain.

In addition to these options, one change in HSAs should surely be made. The HSA contribution rules in place before 2006 should be restored.

When HSAs were first enacted as part of the Medicare drug law in 2003, individuals could contribute to their HSAs on a tax-free basis the lower of the deductible amount under their health insurance plan or the annual HSA contribution limit the legislation set. This rule was changed in 2006, however, to allow individuals to contribute (on a tax-deductible basis) the full amount up to

[15] See Edwin Park and Robert Greenstein, "Latest Enrollment Data Still Fail to Dispel Concerns about Health Savings Accounts," Center on Budget and Policy Priorities, Revised January 30, 2006 and Edwin Park, "Informing the Debate about Health Saving Accounts," Center on Budget and Policy Priorities, June 13, 2006.

the annual contribution limit, *even if the limit substantially exceeds the deductible in their health plan.* In tax year 2009, the minimum high deductible required for family coverage in a plan tied to a HSA was $2,300, while the annual HSA contribution limit was $5,950. Thus, an individual could sock away *$3,650 more* in an HSA than the amount of the deductible under his or her health plan. This substantially increased the tax-sheltering opportunities of HSAs, particularly for high income taxpayers, who were the people who benefited most from the change since they can best afford to contribute the additional amounts.

This change also encourages people with HSAs to increase the amounts they spend on health care. Individuals with HSAs now can "overfund" their HSAs and spend a portion of their excess HSA balances on virtually any health care item or service, including unnecessary care that normal medical practice would not advise and health insurance would not typically cover.[16]

3. Health-related Excise Taxes

Another set of financing options involves excise taxes on products that can undermine good health and impose costs on society. The most obvious such product is tobacco; its deleterious effects on health and the costs that it imposes are well known. Congress significantly increased taxes on tobacco products earlier this year as part of children's health insurance legislation. Whether Congress would be willing to return to this issue again this year is unclear. A case can be made on the merits for further action here.

Since the issue of taxes on tobacco products has so recently been debated and is so well known, I will not discuss it further here. This section of my testimony focuses on issues and options related to: 1) taxing soda and other highly sweetened soft drinks; and 2) adjusting the federal excise tax on alcohol, which has eroded very substantially as a result of inflation since it was last adjusted in the bipartisan deficit reduction agreement of 1990.

To be sure, these excise taxes are regressive. We are talking, however, of options for financing national health care reform that includes universal coverage. The bulk of the Americans who are uninsured have low or moderate incomes. The net effect on this part of the population would be a substantial gain in well-being. Low- and moderate-income households who reduced their consumption of unhealthy products as a result of changes in tax policy also would benefit from improved health outcomes.

A Tax on Highly Sweetened Soft Drinks

Mounting evidence indicates that high-sugar soft-drink consumption has increased sharply in recent years and that this has contributed markedly to increased obesity, which results in higher health costs and increased morbidity. A recent article in *The New England Journal of Medicine,* "Ounces of Prevention: The Public Policy Case for Taxes on Sugared Beverages," makes a strong health case for a federal tax on soft drinks. A few disturbing statistics are worthy of note:

[16] Joel Friedman, Robert Greenstein and Edwin Park, "Last-Minute Addition to Tax Package Would Make Health Savings Accounts More Attractive as Tax Shelters for High-Income Individuals," Center on Budget and Policy Priorities, September 26, 2006.

- Per capita consumption of sugar-sweetened beverages *nearly tripled* from 1977-78 to 2000. By 2003, the average American consumed nearly one gallon of soft drinks a week (46 gallons per year). Americans now consume about 250-300 more calories per day on average than they did several decades ago. The increased consumption of high-sugar soft drinks accounts for *nearly half* of this increase.

- According to a 2001 USDA study, 32 percent of adolescent girls and 52 percent of adolescent boys consume three or more eight-ounce servings of soda per day.

- The increase in obesity, to which has increased soft-drink consumption has contributed heavily, is a significant factor in the higher incidence of diabetes and other diseases. According to the Centers for Disease Control, obesity raises the risk of heart disease, diabetes, stroke, hypertension, certain cancers and other diseases.

- Being overweight as a child increases the risk of developing diabetes, hypertension, respiratory problems and orthopedic problems. Another study published in the *New England Journal of Medicine* concluded that, because of the increase just through 2000 in adolescent obesity, heart-disease deaths by 2035 will rise 6 to 19 percent above what they would have been *without* the increase in obesity.[17]

- Another study found that women who consumed one or more soft drink servings per day were twice as likely to develop diabetes during the eight-year study as women who consumed less than one serving per month.[18]

- Increased obesity also imposes costs on the health care system and taxpayers. Researchers at Emory University have estimated that the "rising prevalence of obesity and [the] higher relative per capita [health] spending among obese Americans accounted for 27 percent of the growth in real capita [health] spending between 1987 and 2001."[19] Increased obesity accounted for 15 percent of the increase in Medicare costs between 1987 and 2002.[20]

- A tax on high-sugar soft drinks would reduce consumption of such beverages — and thereby improve health outcomes. The authors of the recent *New England Journal of Medicine* article estimate that a 10 percent price increase would cut consumption by 7.8 percent.

States are out in front of the federal government here. While only 14 states levied a sales tax on food for home consumption in 2007, some 39 states imposed a sales tax on at least some soda purchases. In some of these states, the tax on soda is simply part of the sales tax that applies to

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[17] "Adolescent Overweight and Future Adult Coronary Heart Disease," *New England Journal of Medicine*, December 6, 2007, http://content.nejm.org/cgi/content/full/357/23/2371#F1

[18] "Sugar-Sweetened Beverages, Weight Gain, and Incidence of Type 2 Diabetes in Young and Middle-Aged Women," *Journal of the American Medical Association*, August 25, 2004, http://jama.ama-assn.org/cgi/content/full/292/8/927

[19] See "The Impact of Obesity on Rising Medical Spending," *Health Affairs*, October 20, 2004, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.480v1

[20] "The Rise In Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence And Changes In Treatment Intensity," *Health Affairs*, August 20, 2006, http://content.healthaffairs.org/cgi/reprint/25/5/w378

food; in others, it is a separate or a higher tax. Some 28 states impose a higher sales tax on vending machine soda sales than on food generally (in most of these states, vending machine snack foods also are subject to the tax), and 20 states impose a higher tax on soda purchased at grocery stores than on other food purchases.

The best option to consider here would be to establish an excise tax on the value of soda, as Arkansas and West Virginia have done. In these states, the tax is levied on distributors, manufacturers, and wholesale dealers. (Both states also levy an equivalent tax on soft drink syrup or dry mix used to make soft drinks.) Health concerns argue for a tax levied in this "upstream" manner — the higher price that results operate as a nudge to reduce consumption of high-sugar beverages.[21]

The *New England Journal of Medicine* article proposed that a tax be set on those products at the rate of a penny per ounce. That would add 12 cents to the price of a 12-ounce soft drink. The authors of the article estimated this would reduce soft-drink consumption by more than 10 percent. On a back-of-the envelope basis, such a proposal should raise something over $10 billion a year, based on a Center for Science in the Public Interest estimate of a similar proposal.

Alcohol Taxes

Federal excise taxes on alcohol now stand at their lowest level in decades. The tax on distilled spirits has been reduced *85 percent* in real terms since 1951 (i.e., after adjusting for inflation). Just since 1991, when alcohol taxes were last adjusted, these taxes have been reduced 37 percent across the board, when inflation is taken into account.

Taxes on alcohol are projected to fall another 8 percent in real terms by 2019.

Looked at another way, federal excise taxes on alcohol equaled 12 percent of gross alcohol sales in 1980. They now amount to about half that, with the percentage falling further every year.

To be sure, moderate alcohol consumption can be neutral or even beneficial for health. But excess alcohol consumption imposes large costs. A study conducted for the National Institute of Alcohol Abuse and Alcoholism by the Lewin Group found that the economic costs of alcohol abuse amounted to an estimated $185 billion in 1998. Such costs include direct medical costs, lost productivity and earnings, and increased crime.

For these reasons, a large group of economists, including four Nobel laureates and three former presidents of the American Economics Association, issued a statement in 2005 calling for increases in excise taxes on alcohol. In addition, the National Academy of Sciences has recommended raising alcohol excise tax rates to discourage underage drinking. Similarly, a 2007 report issued by the Surgeon General noted that increasing the costs of alcohol use (i.e., raising the tax on alcohol) could influence teenagers to drink less.

[21] A soda tax could be administered by the Alcohol and Tobacco Tax and Trade Bureau (TTB), which is housed within the Treasury Department. Under federal law, tobacco products are taxed but are not subject to the level of regulation imposed on alcohol products. The TTB administers tobacco taxes by issuing permits to tobacco manufacturers, importers, and exporters. A parallel system of permits could be instituted for manufacturers, importers, and exporters of soda and soda products.

According to the Centers for Disease Control and Prevention, excessive alcohol use causes about 79,000 deaths per year in the United States.

Raising alcohol taxes to help pay for health care reform also appears to enjoy public support. The Kaiser health tracking poll for April 2009 reports that 68 percent of Americans support increasing wine and beer taxes to help pay for health care reform.

There are various options to raise revenue in this area. As noted, taxes on alcohol were last increased in the 1990 bipartisan budget reconciliation bill, with these increases taking effect in 1991, and have effectively been reduced by 37 percent since then because of inflation. One option would be to raise tax rates back to where Congress set them in 1990 — i.e., to put them at the 1991 level, adjusted for inflation since that time. Under this option, taxes would increase by 4 cents on a bottle of beer, to a total of 9 cents per bottle. They would rise by 3 cents on a glass of wine, to 7 cents per glass.

Another option is one included by the Congressional Budget Office in its recent health care options volume — to set alcohol taxes at a uniform $16 per proof gallon. This CBO option is designed to tax alcohol equally whether it is found in distilled spirits, beer, or wine. Currently, distilled spirits are taxed more heavily.

The current tax on spirits is $13.50 proof per gallon. This CBO option would raise that to $16 per proof gallon and also apply it to beer and wine. Under this option, the tax on a bottle of beer or a glass of wine would rise to about 14 cents — the increase would be 9 cents on a bottle of beer and 10 cents on a glass of wine. According to CBO, this option would raise $60 billion over ten years ($28 billion over five years).

A third option, and the one that would raise the most revenue of the three outlined here, would be to combine the first two options. Under such an approach, alcohol would be taxed across the board at the level that distilled spirits were taxed in 1991, when Congress last acted, with that level adjusted for inflation since 1991 and going forward. Under this option, the tax on a bottle of beer or a glass of wine would be about 18 cents. The increase would be 13 cents per bottle of beer and 14 cents per glass of wine.

An argument may be made in response to these options that unlike tobacco, moderate alcohol consumption is not injurious to health and may even be beneficial. But people who are moderate consumers of alcohol would only be very lightly touched by these proposals. For example, under the first option outlined above, someone who drank a glass of wine with dinner every night throughout the entire year would face a total annual tax increase of $10.85 over the year. Even under the second option under which the tax on wine would rise by 10 cents a glass, the total impact on someone drinking a glass of wine every day of the year would be just $36.50.

4. Capping Itemized Deductions

The President's budget proposes to set a cap of 28 percent on the deduction rate that households with incomes over $250,000 may use. This is the same rate that applied to deductions taken by high-income households in the late 1980s, following enactment of the Tax Reform Act of 1986.

This proposal has attracted criticism for its impact on charities. In fact, the impact on charitable contributions would be relatively modest. Moreover, there is reason to believe that the charitable sector as a whole could be a net gainer if this proposal is combined with effective health care reform.

- Analysis by the Urban Institute-Brookings Tax Policy Center shows that only 1.4 percent of all households would be touched by this proposal.

- Based on the economic research in the field, total charitable contributions would be expected to decline by slightly less than 2 percent.

And there would be some benefits for charities.

- Universal coverage would relieve the charitable sector of the need to finance billions of dollars a year in charity health care.

- Small non-profits that now must pay high health care premiums likely would be able to obtain health coverage for their employees at lower cost through a health insurance exchange.

This is why I believe charities as a whole would be more likely to be net winners than net losers from the combination of this proposal and health care reform.

A criticism that this would place too heavy a tax burden on high-income households also seems misplaced. Analysis by the Tax Policy Center shows that if the various tax measures President Obama has proposed were adopted — including the itemized deduction cap — the effective tax rate on each income group, up through and including the top 1 percent of households, would be lower than it was in late 1990s when the economy boomed and high-income households did well.

Despite the strong criticisms that have been made of the Administration's proposal, I would urge the Committee not to take this approach entirely off the table. There are alternative options, designed to address the criticisms that have been voiced of the Administration's proposal, that warrant serious consideration. Two such options are:

- Exempt charitable contributions from the President's proposal; or

- Apply a cap to all itemized deductions but set the cap at 33% and/or 35%, rather than at 28%.

Today, filers deduct at the 33% rate if they are in the next-to-the-top tax bracket, and at 35% if they are in the top bracket. The tax rates in these two brackets are slated to go back to 36% and 39.6% in 2011. Congress could cap itemized deductions at the rates that *currently apply*. Or Congress could simply cap deductions at 35% (rather than at the 28% level the President proposed).

Under such an approach, the value of itemized deductions — and the incentive to donate — *would not change* from what it is today. The criticisms that have been voiced of the Administration's proposal — that it would increase the cost of donating, relative to what it is today — would not be applicable. Meaningful savings would still be generated to help finance health care reform, although at a considerably lower level than the Administration's proposal envisions.

Another alternative would be to dispense with an itemized deduction cap and instead to place a tax surcharge on income about a very high level.